Document Version: 13.1
Document Date: 11/5/99

EIS Version Reference: 13.1
EIS Projected Date: 12/2/99

DEERS/Medical

Interface Operational Description

Prepared for

The Office of the Undersecretary of Defense

Personnel and Readiness

And

The Defense Manpower Data Center

Print Date: January 9, 2001

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Interface Operational Description

Document Issue History from Version 13 to Version 13.1

General Changes

- Incorporated the TMA requirement for DEERS to be able to store additional information for providers within the civilian network.
- Changed various attribute names to be consistent with the DoD naming conventions and standards.
- Added TRICARE Remote coverage plans for active duty family members.
- Added Federal Employees Health Benefits Program (FEHBP) health care delivery program.
- Added text to clarify that DEERS will return NAS information based on the issue date of the NAS and will include cancelled NAS if applicable.
- Restructured the capture and return of catastrophic cap and deductible data. Accumulations will be separated by fiscal and enrollment year within their respective health care delivery programs.
- Restructured Eligibility and Coverage sections.
- Modified language referencing claims to refer to catastrophic cap and deductible.

Duplicate Person Identification

- Included the Patient Id in the Partial Match response.

Eligibility for Enrollment

- Moved this business event to the Enrollment section.
- Added new section detailing the HCDP Plan Status (e.g., assigned, enrolled and eligible for coverages).
- Clarified that DEERS will support inquiries from 60 days in the past to support retroactive enrollments.
- Added a program code (e.g., Prime, USFHP) to identify the health care delivery program for the inquiry. DEERS will return current coverage and only the coverage plans that the beneficiary is “eligible for” for the requested program.

Health Care Coverage (formerly Claims Coverage)

- A new section, entitled Health Care Coverage, has been added. This section includes a General Health Care Coverage Inquiry and a Health Care Coverage Inquiry for MTFs. The Coverage Inquiry for Claims has been renamed Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity and has been moved to the Catastrophic Cap and Deductible Data section.

Dental Coverage Inquiry

- This section was removed because dental requirements are contained in a separate document.

Enrollment Events

- Added text to clarify the changing of enrollment begin dates and the effect on the enrollment anniversary date and enrollment fee paid-through date.
- Created a separate event to add a newborn to DEERS from an MTF using the sponsor's Patient Id.
- Added text to clarify portability does not exist between health care programs (e.g., TRICARE and USFHP).
- Added text to clarify how DEERS supports continuous enrollments.
- Added a new business event, Enrollment Fee Payment Transaction History Request.
- Removed concept of incomplete vs. complete enrollments based on fee information sent to DEERS, because DEERS does not edit the payment amount based on the amount due for for the coverage plan.
- Removed all references to MTFs as enrolling organizations and CHCS as an enrollment management system, because CHCS will no longer perform enrollment functions.
- Added Medicare Health Insurance Claim Id as required data to enroll a beneficiary into TRICARE Senior Prime.
- Added Enrollment Notification section.
- Added Enrollment Fees and Fee Waivers section.
- Clarified that when an enrollment is cancelled, catastrophic cap and deductible accumulations will remain intact. If they must be adjusted, the amounts should do this prior to canceling the enrollment.
- Added a family enrollment end reason code that will trigger DEERS to disenroll all insureds under a policy.
- Added text to clarify that for split enrollments, if DEERS disenrolls family members for failure to pay fees and then the end reason code is changed (to a non-family disenrollment), DEERS will reinstate enrollments in other regions.

General Updates

- Renamed Person Updates to Beneficiary Updates.
- Incorporated the TMA requirement for capturing both a residence mailing address and a correspondence mailing address.
- Clarified that, for Patient Adds, if the submitted SSN matches an SSN already stored on DEERS, DEERS will create and return a Temporary Id, indicating that the SSN could not be stored due to duplication.

Catastrophic Cap and Deductible Events

- Added text to clarify that pharmacy systems cannot lock or update catastrophic cap and deductible information.
- Included the claim period of service dates when updating catastrophic cap and deductible amounts associated with a claim.
- Added a new business event, Catastrophic Cap and Deductible Transaction History Request.
- Included the Patient Id in the response to a Catastrophic Cap and Deductible Totals Inquiry for Health Care Service Record reporting.

Other Health Insurance

- Added the Uniform Business Office as the functional proponent for Other Health Insurance (OHI).
- Clarified the requirements for business events associated with OHI policies.
- Added two new OHI coverages, Partial Hospitalization and Skilled Nursing Care.
- Added a generic OHI policy of "Unknown" which may be used to indicate that a beneficiary has OHI, but the specifics of the policy are not known.

Standard Insurance Table

- Added the Uniform Business Office as the functional proponent for the Standard Insurance Table (SIT).
- Clarified the requirements for business events associated with the SIT.
- Added a new business event, SIT Cancellation.
- Added text explaining the deactivation of a health insurance carrier from the SIT.
- Removed Temporary Carrier Id. DEERS will now use the Health Insurance Carrier Id Type Code to differentiate between verified and temporary Ids.

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Contents

FIGURES

1 Scope

1.1 Purpose

This document provides information on how the requirements within the DEERS/Medical System/Subsystem Specification, September 1998, will be implemented within redesigned Defense Enrollment Eligibility Reporting System (DEERS). This document will detail the following:

- Terminology used within redesigned DEERS
- Functional events from Military Health System (MHS) that trigger a request to inquire and/or update data within DEERS
- "Rules of the road" for accessing and updating data within redesigned DEERS
- Methodology for identifying individuals within redesigned DEERS

1.2 System Overview

1.2.1 Program Description

DEERS serves as a centralized Department of Defense (DoD) data repository of personnel and medical data. The DEERS database contains detailed personnel eligibility information for benefits and entitlements distribution to Uniformed Services[1] members; United States (U.S.) sponsored foreign military members; DoD and Uniformed Services civilians; other personnel as directed by the DoD; and their eligible family members. DEERS supports essential day-to-day operations in a broad range of functional areas, including personnel, medical, and finance.

DEERS is updated by batch transactions from the Uniformed Services' automated personnel, finance, medical, and mobilization management systems, and the Department of Veterans Affairs (VA). DEERS is also accessed and updated by online DEERS client applications, such as the Real-Time Automated Personnel Identification System (RAPIDS), and interfacing client systems of the Military Health System (MHS), such as the Composite Health Care System (CHCS). DEERS helps detect and prevent fraud and abuse in DoD benefits and entitlements distribution.

DEERS access is real-time from sites worldwide via the Defense Information Systems Network (DISN) and local area networks (LANs). TRICARE contractors, Uniformed Services military and dental treatment facilities, and personnel offices access the DEERS

[1] The seven Uniformed Services are: U.S. Army, U.S. Navy, U.S. Marine Corps, U.S. Air Force, U.S. Coast Guard, their National Guard and Reserve components, U.S. Public Health Service (USPHS), and the National Oceanic and Atmospheric Administration (NOAA) Commissioned Corps.

database approximately 1,193,000 times per day. Database access volume will continue to grow.

The existing DEERS architecture uses a Virtual Storage Access Method (VSAM) environment with two separate and different physical DEERS databases, Enrollment and Eligibility. The Enrollment database resides at the Naval Postgraduate School (NPS) Computer Center in Monterey, California, and the Eligibility database resides at a contractor System Management Center (SMC) located in Auburn Hills, Michigan.

DEERS provides and receives updates to enrollment and eligibility verification data from existing DEERS client applications and interfacing client information systems, as well as from other DoD, Uniformed Services, and non-DoD information systems, in accordance with DoD Directive 8000.1, "Defense Information Management (IM) Program," dated 27 October 1992, Reference (3). It provides statistical and demographic data to support DoD and Uniformed Services peacetime and wartime missions. DEERS maintains casualty identification data on members of the Uniformed Services, and other personnel as designated by DoD, to support casualty identification and verification of entitlement eligibility for surviving family members.

DEERS maintains information that helps make administration of the MHS more effective and efficient, along with other benefit and entitlement systems which derive basic eligibility information from DEERS. DEERS also provides and maintains medical and personnel readiness information on Uniformed Services members and other personnel as designated by the DoD. It maintains data on Uniformed Services members and retired sponsors to facilitate eligibility verification for Government educational programs, for example, the Montgomery GI Bill (MGIB). DEERS helps make Uniformed Services members, other personnel as designated by the DoD, and their family members more aware of their benefits and entitlements, which are verified through DEERS. It improves the timeliness of providing DoD benefits and entitlements to Uniformed Services members, other personnel as designated by the DoD, and their family members.

DEERS serves as DoD's centralized personnel locator service, in accordance with Section 113 of 10 United States Code (U.S.C.)[2] by maintaining current addresses for members of the Armed Forces, and providing those addresses upon request to the Federal Parent Locator Service of the Department of Health and Human Services' Office of Child Support Enforcement. It maintains the right index fingerprint[3] of all eligible individuals in a pay or annuity status, including active duty and Reserve military personnel, retired sponsors, survivors receiving annuity payments derived from the service of a deceased person, and civilian employees with identification cards issued through RAPIDS. The Undersecretary

[2] Section 113 of Title 10, United States Code, "Enforcement of Child Support Obligations of Members of the Armed Forces," Reference (4).

[3] The right index fingerprint will be kept for use by the USD (Comptroller), as authorized by USD (P&R) memorandum, "Fingerprint Capture Policy," dated 15 July 1997, Reference (5).

of Defense (USD) (Comptroller) uses these fingerprints to improve service member identification and verification techniques.

1.2.2 DEERS Users

DEERS supports multiple functional communities, as well as multiple user levels within those communities. DEERS users include Federal (DoD and non-DoD) Government agencies and organizations; state government agencies; and Government support contractors who access DEERS data through DEERS' client applications or the user's interfacing client system.

DEERS data users include:

1. Benefits and entitlements providers[4] for eligibility verification in conjunction with claims processing and providing or denying services
2. Uniformed Services personnel activities, recruit reception centers, and academies that add or update individual beneficiary DEERS data and issue the Uniformed Services identification (ID) cards
3. Health care managers, health benefits advisors (HBAs), and specialists in DoD medical and dental communities
4. Defense Manpower Data Center (DMDC) Support Office (DSO) staff who perform beneficiary and user support operations
5. DoD and Uniformed Services executive community, which uses DEERS statistics and demographic data for a number of functions

The Office of the USD (OUSD) for Personnel and Readiness (P&R) and the DEERS RAPIDS Program Office (DRPO) maintain contact with DEERS users through the Joint Uniformed Services Personnel Advisory Committee (JUSPAC), the Joint Uniformed Services Medical Advisory Committee (JUSMAC), and the Joint Uniformed Services Dental Advisory Committee (JUSDAC). These committees are composed of functional members from the personnel, medical, and dental communities within the active duty, National Guard, and Reserve components. Members of the personnel, medical, and dental communities who function at the level of the Office of the Secretary of Defense (OSD) support these committees.

[4] Benefits/entitlements providers include the Uniformed Services Military Treatment Facilities (MTFs), Dental Treatment Facilities (DTFs), Uniformed Services Treatment Facilities (USTFs) or Designated Providers, Military Health System (MHS) managed care support contractors (MCSCs), Continued Health Care Benefit Program (CHCBP), TRICARE Family Member Dental Program (FMDP) contractor, TRICARE Selected Reserve Dental Program (TSRDP) contractor, TRICARE Retiree Dental Plan (TRDP) contractor, Base Realignment and Closure (BRAC) Pharmacy and National Mail Order Pharmacy (NMOP) contractor, Social Security Administration (SSA), Department of Veterans Affairs (VA), Health Care Financing Administration (HCFA), DoD Commissary Agency, Uniformed Services exchange systems, and Uniformed Services Morale, Welfare, and Recreation (MWR) agencies.

1.2.3 Current Status

DEERS is being redesigned as an *integrated system* consisting of a database; rules for benefits and entitlements eligibility determination and data reconciliation; a set of functional applications; and interfaces to other systems, as required. The DEERS database, rules, and interfaces will be mainframe-based. The database uses a relational database management system (RDBMS). An expert system package will be used to code, store, and apply the DEERS business rules.

Most DEERS operational functionality will reside in its client applications that reside on end user platforms, and their supporting knowledge bases (KBs) on the central system. Client applications may be developed by functional proponents for authorized access to DEERS in coordination with DMDC. They may also be developed by DMDC to address specific functional requirements identified by functional proponents. The client applications will reside on the user's personal computer (PC) and/or network server or host. Data will be shared among user applications from an enterprise-wide database.

DEERS will use an open systems approach built in a modular fashion. DMDC will coordinate with the Defense Information Systems Agency (DISA) to meet the established technical and data standards for interoperability and to verify required DEERS interoperability, prior to Program Milestone III increments. One copy of the redesigned relational database will reside at a contractor System Management Center (SMC) located in Auburn Hills, Michigan. A second copy will reside at the NPS Computer Center in Monterey, CA.

To preclude any significant interruption of service, development, operational testing, and implementation are being conducted incrementally, while the existing system remains in operation, until redesigned DEERS has achieved a steady state of reliability. Implementation in overlapping phases means that while worldwide client application fielding occurs, different user communities are serviced, and functionality is expanded. Proof of concept was successfully demonstrated in 3d Quarter Fiscal Year (FY) 1997 with the redesigned Tumor Registry satellite database and application fielding.

Operational testing has been completed for the personnel application (RAPIDS) and its associated interfaces. In FY 1998, RAPIDS began worldwide fielding. Development of applications supporting DSO and other DMDC units, and software supporting the batch processing, specifically uniformed services source update processing and standard periodic report generation requirements, is ongoing.

By December 31, 1999, the application supporting DSO and other DMDC units will be fielded, and the current[5] Enrollment database will be turned off.

Development of the application(s) supporting the medical requirements defined in the "DEERS/Medical System/Subsystem Requirements Specification," dated September 1998, Reference (7), is underway. Operational testing of the medical application(s) will be

[5] Throughout this Interface Operational Description, the term *current* refers to DEERS as it exists on this document's date of issue. Please refer to the Document Issue History page immediately before the Table of Contents for more information.

coordinated by OASD for Health Affairs (HA). It will take approximately one year to field the medical application(s) across the MHS and the various TRICARE Managed Care Support Contractors (MCSCs).

The current Eligibility database will migrate as a buffered application to Redesigned DEERS. When all remaining current client applications and interfacing client systems have successfully migrated to the redesigned DEERS database, the current Eligibility database will be taken out of service.

The DEERS Eligibility System was granted a three-year information security accreditation in January 1995. Ordinarily, reaccreditation would be accomplished during calendar year 1998 because of the three-year time limit levied on all automated information systems (AIS) accreditations. However, DEERS has been redesigned since the 1995 accreditation. Additionally, the requisite certification and accreditation activities have been streamlined and redefined in the Defense Information Technology Security Certification and Accreditation Process (DITSCAP), Reference (2). Because the Eligibility System's security posture has undergone few changes since the last reaccreditation and the redesigned DEERS is ready for implementation, the current Eligibility System accreditation will be extended for 120 days. Accreditation resources will focus on the redesigned DEERS interim accreditation in conjunction with the Eligibility System's reaccredidation. Combining two separate but overlapping efforts will conserve resources, minimize operational impact, and still fulfill requirements for reaccreditation. Extending the existing DEERS Eligibility System accreditation and reaccreditation is necessary, since the Eligibility System will continue to run until the MHS migration is completed.

An intermim approval to operate (IATO) DEERS was granted in 1998. As an ongoing measure, an abridged System Security Authorization Agreement (SSAA) is in development. The abridged SSAA supports the continued migration of the mainframe DEERS system to the relational database model and expanded medical functionality. At each subsequent initial operational capability (IOC), the DEERS abridged SSAA will be updated with the appropriate system changes, following the DITSCAP procedures until the redesigned DEERS reaches full operational capacity (FOC). This migration will be completed at full operational capability (FOC).

1.2.4 History

The DoD provides certain benefits and entitlements, such as medical and dental care, commissary, exchange, and morale, welfare, and recreation (MWR) privileges, to its Uniformed Services members, certain civilian employees, and their family members. DEERS was initiated to improve the control and management of how these benefits and entitlements are distributed.

Originally, DoD medical care was provided only by military hospitals and dental clinics. Medical care provided by civilian sources was first authorized for eligible family members of active duty Uniformed Services members (including National Guard and Reserve component members on active duty in excess of 30 days) on December 7, 1957. During January 1967, civilian medical care was extended to retired service members, and their eligible family members, as well as to widows and widowers of deceased service members.

In 1981, civilian medical care was extended to family members of North Atlantic Treaty Organization (NATO)-sponsored foreign military members serving in the U.S. The program providing medical care by civilian sources was called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) until 1996, when it was renamed DoD Managed Care Program, TRICARE. TRICARE is currently governed by 32 Code of Federal Regulations (CFR) Part 199, Reference (7).

Based on several General Accounting Office (GAO) investigative audits of accountability deficiencies in the CHAMPUS program, the GAO published "Potential for Improvements in the Civilian Health and Medical Program of the Uniformed Services (Summary Report)," dated 19 July 1971, Reference (9). This report identified the use of the Uniformed Services ID cards issued to Uniformed Services members, retired sponsors, DoD and Uniformed Services civilians, State Department employees, NATO-sponsored foreign military members, and their eligible family members, as insufficient tools to manage military medical care and contain the growth of CHAMPUS costs. The report provided recommendations for improving military medical care and CHAMPUS program management.

In response to the GAO report, the OASD for Health and Environment (H&E) created the Health Personnel All-Volunteer Task Force to study the report's conclusions and recommendations, and to offer corrective solutions to Congress. Between 1971 and 1975, studies conducted by the Health Personnel All-Volunteer Health Task Force; the Center for Advanced Studies; the GAO; and the Assistant for Audit Operations, OASD (H&E) (Comptroller), indicated that fraudulent use of military health care services cost the DoD approximately $60 million annually. This $60 million included approximately $20 million in unauthorized direct care services provided at military treatment facilities (MTFs), and approximately $40 million in unauthorized CHAMPUS claims payments.

Based on the findings in these reports, the House Appropriations Committee Report for Fiscal Year 1975 (No. 93-1255), Reference (9), directed the DoD to: (1) initiate a program to improve the control and distribution of available military health care services; (2) project and allocate costs for health care programs; and (3) minimize fraudulent use of military health care benefits and entitlements by unauthorized persons.

After two years of study, the OASD (H&E) Health Studies Task Force published *The Health Beneficiary Enrollment Eligibility System for the Department of Defense* working paper in February 1977, Reference (10). This paper concluded that the best method to deter fraudulent use of medical services was to institute eligibility verification. This verification required that an automated, centralized system be established to contain the names of all eligible beneficiaries and match or link those beneficiaries to specific sponsors.

The working paper acknowledged that the DoD and the seven Uniformed Services already had a basic eligibility verification vehicle in place, namely the Application for the Uniformed Services Identification and Privilege Card (Department of Defense [DD] Form

1172)[6]. This form was completed by the sponsor and used by the Uniformed Services to authorize issuance of the DoD Uniformed Services Identification and Privilege Card (DD Form 1173) to family members. The DD Form 1173 authorized the family member's access not only to medical care, but also to DoD commissary, exchange, and MWR benefits or entitlements. The DD Form 1172 could serve as the enrollment form for the centralized beneficiary system, and the DD Form 1173 could serve as the membership card certifying eligibility for benefits or entitlements. Since DoD and Uniformed Services procedures were already in place to issue both DD Form 1172 and DD Form 1173, using these forms would not require additional training for the Uniformed Services personnel completing or processing the forms.

The next steps were to identify the functional and technical requirements for an automated centralized beneficiary system that would support the beneficiary enrollment and eligibility verification concept, and to build a demonstration model. The Enrollment Demonstration System was completed in 1978. Based on the Enrollment Demonstration System's successful operation, both the House and Senate Appropriations Committee Reports of December 1979 (for FY 1980) recommended funding for DoD enrollment and eligibility verification project. Following congressional approval of the funding, the OASD (HA) and the OASD for Manpower, Installations, and Logistics (MI&L) established the DEERS Project.

In early 1980, the DEERS Project evolved into the DEERS Program. On October 14, 1981, the Deputy Secretary of Defense (DepSecDef) published DoD Directive (DoDD) 1341.1, "Defense Enrollment Eligibility Reporting System (DEERS)," Reference (11), that officially established the DEERS Program; the DEERS PM position; the DEERS Program Office (DPO); and assigned overall policy and procedural responsibilities for the DEERS Program jointly to the ASD (HA) and the Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics (ASD [MRA&L]).

On March 2, 1982 the Deputy Secretary of Defense (DepSecDef) published DoD Instruction (DoDI) 1341.2, "Defense Enrollment Eligibility Reporting System Procedures," Reference (12), which: (1) further delineated the specific responsibilities of the DPO PM; and (2) created the DEERS Steering Group, DEERS Steering Group Secretariat, DEERS Work Groups and Work Group Committees, and the Configuration Control Board.

In 1982, the DoD expanded the DEERS Program to include verification of beneficiary eligibility for non-medical benefits and entitlements to commissary, exchange, and MWR. This expansion was based on the need to control fraud, waste, and abuse in the management of DoD non-medical benefits and entitlements that were previously mandated by Congress in Title 10 U.S.C., Chapter 54. Since DD Form 1172 and the ID card were already in use to validate these benefits and entitlements, as well as to verify eligibility for medical entitlements, it made sense to include verification for all benefits and entitlements in DEERS.

[6] The DD Form 1172 was redesigned in 1981 and renamed the "Uniformed Services Identification Card and DEERS Enrollment."

In 1985, the OASD (HA) established the Reportable Disease Database (RDDB) to collect information on reportable infectious diseases. This DEERS client application collects information on Human Immunodeficiency Virus (HIV) infection test results from all service military members and from certain DoD and Uniformed Services civilian employees. The RDDB can collect information on other diseases, such as hepatitis. The negative or positive results of these HIV tests are reported to the DEERS Division for test registration into DEERS. The data in the RDDB is extremely sensitive and can only be accessed online by designated persons in the Offices of the Surgeons General of the Uniformed Services. The DEERS database reports a *Yes* flag for the HIV test, which indicates only that a test was taken, and the date the test went on file. Personnel community users are restricted to viewing only *Yes* or *No* flags and test registration dates for this medical data.

In 1986, the DEERS mission was expanded by Congress[7] to include enrolling non-active duty National Guard and Reserve members and their eligible family members. This enrollment supported the DoD mission to project future military medical costs in the event of the activation and/or mobilization of these National Guard and Reserve members; and to estimate future MTF, CHAMPUS, and space available (contract) dental care costs for their family members. Additionally, this enrollment supported eligibility verification for commissary, exchange, and MWR benefits or entitlements which Title 10 U.S.C., Chapter 54 authorized for this population.

Also in 1986, for FY 1987[8], Congress modified Title 10 U.S.C., Chapter 55 to direct the DoD to develop and implement a dental insurance plan for CHAMPUS-eligible family members of active duty and National Guard and Reserve sponsors who were on active duty orders for at least 24 months. The DEERS mission was again expanded to support eligibility verification for this program, which was titled the Uniformed Services Active Duty Dependent Dental Plan (DDP), and subsequently renamed the TRICARE Active Duty Family Member Dental Plan (FMDP) program.

Between 1986 and 1990, DEERS expanded further when several client applications (interfacing client systems) were developed to support the medical community. These client applications were and are still used to add and update tumor data, and to add the storage location of the duplicate dental pan-oral radiograph (Panograph) used for casualty identification. Personnel community users are restricted to viewing the date of the most recently received Panograph. The client applications and interfacing client systems allowed the medical community user to view beneficiary eligibility data in read-only mode, and to update beneficiary residential addresses and telephone numbers.

Because certain DoD military installations were to be closed, the National Defense Authorization Act for FY 1993 required the DoD to include a mail order and retail pharmacy program in all managed care programs initiated, awarded, or renewed after January 1993. This program is referred to as the Base Realignment and Closure (BRAC)

[7] National Defense Appropriations Bill for Fiscal Year 1986.

[8] National Defense Appropriations Bill for Fiscal Year 1987.

Pharmacy program. The BRAC Pharmacy program applies to DoD beneficiaries, including Medicare-eligibles, residing in the vicinity of a BRAC-closed installation. A *Yes* flag is posted in the Medicare-eligible's DEERS record to show BRAC Pharmacy enrollment. This flag can be viewed through the medical inquiry section of the Government Inquiry of DEERS (GIQD) application. The BRAC Pharmacy contractor uses a proprietary application to view the BRAC enrollment data. Mail-order pharmacy benefits is administered through the National Mail Order Pharmacy (NMOP).

In July 1997, the DEERS mission was once again expanded to store the right index fingerprint[9] of all eligible individuals in a pay or annuity status, including active duty and Reserve military personnel; retired sponsors; survivors receiving annuity payments derived from the service of a deceased person; and entitled civilian employees to be used by the USD (Comptroller). This improved service member identification and verification techniques. In October 1997, DEERS was tasked to serve as the Department's centralized personnel locator service in accordance with Section 113 of 10 U.S.C.[10] by maintaining current addresses for members of the Armed Forces, and providing addresses upon request to the Federal Parent Locator Service of the Department of Health and Human Services' Office of Child Support Enforcement. The TRICARE Selected Reserve Dental Program (TSRDP) was also implemented in 1997. In 1998, the TRICARE Retiree Dental Program (TRDP) was implemented. The DEERS mission expanded to support eligibility determination for both dental programs.

Earlier attempts at a partial DEERS redesign included an Application Merge effort to consolidate online applications accessing the Eligibility Database, and an Enrollment Sponsor Redesign, initiated to modularize and incorporate tables in the existing Enrollment Database's software. In 1994, DEERS was designated as an OUSD (P&R) migration system. To ensure DEERS' orderly evolution to an open systems environment and conformance with DoD standards, the Enrollment Eligibility Reconciliation (E^2R) project was begun in January 1995. This project was initiated to reengineer the DEERS data model. The new data model would implement new business rules using rules-based tables to derive Uniformed Services benefits/entitlements, and capitalize upon many advances in hardware, software, and system design techniques. This new data model would improve data quality and overcome DEERS' limitations of inflexibility, high maintenance and modification costs, and inefficiency. Analyzing benefit categories and the rules of eligibility applied to them clearly indicated that the benefits/entitlements rules could be defined to support automated determination of the benefits/entitlements eligibility set.

Because RAPIDS is the primary means for updating eligible family member information in the DEERS Eligibility Database, it was chosen as the first client application to be reengineered for compatibility with the redesigned DEERS environment. Together,

[9] The right index fingerprint will be kept for use by the USD (Comptroller), as authorized by the USD (P&R) memorandum, "Fingerprint Capture Policy," dated 15 July 1997, Reference (f).

[10] Section 113 of Title 10, United States Code, "Enforcement of Child Support Obligations of Members of the Armed Forces," Reference (e).

DEERS and RAPIDS reengineering efforts were known as the Enrollment Eligibility RAPIDS Reconciliation project. In September 1996, to eliminate confusion, the project was renamed the DEERS Redesign Project.

1.2.5 Objective

The DEERS Redesign Project was undertaken to accomplish the following:

1. Ensure correct and consistent benefits determinations by eliminating manual determinations.
2. Increase responsiveness to changes in the laws and regulations governing Uniformed Services entitlements and benefits.
3. Establish a common operating environment (COE) based on the open systems specifications contained in the Technical Architecture Framework for Information Management (TAFIM), Reference (1); the Defense Information Infrastructure (DII) Strategic Enterprise Architecture, Reference (13); and the DII/COE Integration and Runtime Specification (IRTS), Reference (14).
4. Establish a standard DEERS interface(s) for client AISs.
5. Store raw data, which is captured at the lowest level, in the DEERS database instead of storing derived data.
6. Eliminate redundant software applications to decrease software maintenance requirements.
7. Simplify software distribution to reduce the time and effort required for software release implementation.
8. Improve software maintainability to reduce the number of system and software engineers required to support future software releases, and allow for shorter software development and production cycles.
9. Improve extensibility so that data may be added to the database without disrupting existing applications or interfacing systems, and can be reorganized for faster processing or to take advantage of new data elements.
10. Provide each DEERS client application with its own independent view or interpretation of the data without the need to duplicate data or store the various interpreted data values.
11. Position DEERS to accommodate future requirements, such as providing a standard means to collect insurance information to support DoD Third Party Collections (TPC) and claims management; enrolling DoD civilians and Foreign Military members and their family members; supporting TRICARE active duty FMDP online enrollments and disenrollments; and storing fingerprints and facial images.

12. Improve and expedite report generation capabilities to reduce the effort required to maintain or modify standard periodic reports, as well as to facilitate new standard and *ad hoc* report generation.

1.3 Document Overview

The document will describe how DEERS will communicate electronically with the DoD community using the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 and ANSI ASC HL7 interfaces. These interfaces will subsequently be referred to as *X12* and *HL7*.

This document is divided into the following sections:

- Section 1 describes the scope of this document.
- Section 2 lists the documents that are referenced within this document.
- Section 3 presents the basic terms and concepts necessary to understand redesigned DEERS and its interfaces.
- Section 4 presents an overview of the interface design.
- Section 5 details the functions supported within the redesigned DEERS interface.
- The last portion of this document contains several appendices including a list of acronyms, a glossary of terms, and the Coverage Plan Matrix. Attached Appendixes include the IOD Business Rules Matrix, Redesigned DEERS Database Roles, and Business Scenario Examples.

2 Referenced Documents

Documents Referenced by Numbers

1. Technical Architecture Framework for Information Management.
2. Defense Information Technology Security Certification and Accreditation Process.
3. DoD Directive 8000.1, "Defense Information Management Program," dated 27 October 1992.
4. Section 113 of Title 10, United States Code, "Enforcement of Child Support Obligations of Members of the Armed Forces".
5. Undersecretary of Defense for Personnel and Reserve Affairs Memorandum, "Fingerprint Capture Policy," dated 15 July 1997.
6. "DEERS/Medical System/Subsystem Requirements Specification," dated September 1998.
7. 32 Code of Federal Regulations (CFR), Part 199.
8. General Accounting Office Summary Report, "Potential for Improvements in the Civilian Health and Medical Program of the Uniformed Services," dated 19 July 1971.
9. House Appropriations Committee Report for Fiscal Year 1975 (No. 93-1255).
10. Office of the Assistant Secretary of Defense for Health and Environment Health Studies Task Force Working Paper, "The Health Beneficiary Enrollment Eligibility System for the Department of Defense," dated February 1977.
11. Department of Defense Directive 1341.1, "Defense Enrollment Eligibility Reporting System (DEERS)," dated 29 May 1999.
12. Department of Defense Instruction (DoDI) 1341.2, "Defense Enrollment Eligibility Reporting System Procedures," dated 19 March 1999.
13. Defense Information Infrastructure Strategic Enterprise Architecture.
14. Defense Information Infrastructure/Common Operating Environment Integration and Runtime Specification.

Other Referenced Documents

- *National Electronic Data Interchange Transaction Set Implementation Guide*, "ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response, Version 004010X092," Insurance Subcommittee, Washington Publishing Company, May 1999
- *National Electronic Data Interchange Transaction Set Implementation Guide*, "ASC X12N 278 Health Care Services Review - Request for Review and Response, Version 004010X094," Insurance Subcommittee, Washington Publishing Company, May 1999
- *National Electronic Data Interchange Transaction Set Implementation Guide*, "ASC X12N 278 Health Care Services Review – Notification, Version 004010X111," Insurance Subcommittee, Washington Publishing Company, October 1998
- *National Electronic Data Interchange Transaction Set Implementation Guide*, "ASC X12N 278 Health Care Services Review – Inquiry and Response, Version 004010X059," Insurance Subcommittee, Washington Publishing Company, November 1998
- *National Electronic Data Interchange Transaction Set Implementation Guide*, "ASC X12N 834 Benefit Enrollment and Maintenance, Version 004010X095," Insurance Subcommittee, Washington Publishing Company, May 1999
- DEERS Data Dictionary
- Privacy Act of 1974
- Defense Logistics Agency Regulation 5400.21
- Department of Defense Standard 5200.28-STD
- Department of Defense Instruction (DoDI) 1000.13, "Identification Cards (ID) for Members of the Uniformed Services, Their Dependents, and Other Eligible Individuals," dated 1 December 1997.
- DEERS/MHS System/Subsystem Requirements Specification, dated September 1998
- ANSI ASC X12 Standards, Version 4 Release 1, December 1997

3 Concepts and Definitions for Redesigned DEERS

3.1 Introduction

Redesigned DEERS is designed around the concept of a "person," whereas the current DEERS is a beneficiary-based system. For example, currently DEERS contains data only on people who have entitlement to DoD health care or other benefits. Redesigned DEERS is a person repository that contains all of the beneficiaries within the current DEERS plus the capability to store information for people who are not eligible for DoD benefits. Additionally, within redesigned DEERS, interfaces with external systems will be based on commercial standards. To this end, DEERS will use commercial Electronic Data Interchange (EDI) standards in accordance with the American National Standards Institute (ANSI) Accredited Standards Committee (ASC). DEERS will interface with external systems using ANSI ASC X12 and ANSI ASC HL7, and will adopt standard insurance industry terminology.

3.2 Types of Data Redesigned DEERS Uses and Stores

Four basic types of information--Person/Personnel, Beneficiary, Medical Benefit, and Clinical Summary--can be stored and provided to the MHS through a central repository. Each is detailed below.

3.2.1 Person and Personnel Information

This is basic characteristic data about individuals, including both affiliations to DoD organizations or organizations designated by DoD, and affiliations within family units. Although historical data is also available for applications such as longitudinal studies and demographic trend analysis, only current data is required for day-to-day clinical operations. Some of this information is provided and maintained by the DoD medical community along with other DoD sources.

3.2.1.1 Person Data

Primary (internal) identification — A mutually agreed-upon internal identifier shared between the repository and external systems

Secondary (external) identification — Name, Social Security Number (SSN), date of birth

General characteristics — Sex, blood type, etc.

Person-based programs — Organ donor

Family association— Self, child, etc.

Contact information — Address, telephone number

3.2.1.2 Personnel Data

Personnel category — active duty, reserve, retired, etc.

Service or organization — Army, Navy, DoD civilians, etc.

Position — Rank

Personnel readiness programs — Panograph[11], RDDB, DNA

3.2.2 Beneficiary Information

This information combines the underlying rules-based system that captures DoDI 1000.13 *Identification (ID) Cards for Members of the Uniformed Services, Their Dependents, and Other Eligible Individuals* and other applicable regulations and procedures with enrollment information, as maintained by the MHS community. This data is provided for past, current, and future periods from the inquiry date, and consists of specific health care delivery program (HCDP) information.

Examples of this information are:

- DoD Health Care Delivery Programs: DoD HCDPs are defined by DEERS as the methods of providing basic health and dental benefits. Examples of these include TRICARE, TRICARE Uniformed Services Family Health Plan (USFHP), Federal Employees Health Benefit Program (FEHBP), and Continued Health Care Benefit Program (CHCBP).
- Other Government Programs: Other government programs are defined by DEERS as programs or plans provided and supported by a U.S. Government agency other than the DoD. The two current types of programs stored in DEERS are Medicare and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).
- Other Health Insurance (Commercial): Other Heath Insurance (OHI) information is also stored in DEERS to support third party collections.

3.2.3 Medical Benefit Information

3.2.3.1 General Policy

Examples of medical benefit information that DEERS will track on a policy level include:

- Deductible accumulation
- Catastrophic cap accumulation
- Enrollment fee accumulation

[11] Panograph collection terminates December 1999. DEERS is awaiting a policy decision regarding providing this information via an interface or online application after December 1999.

3.2.3.2 Person Related

Examples of medical benefit information that DEERS will track on a person level include:

- Nonavailability statement data
- Other health insurance
- Enrollment fee waiver information

3.2.4 Clinical Summary Information

The Automated Central Tumor Registry (ACTUR) database, which is a satellite database to DEERS, contains specific and summary information about the diagnosis and treatment of cancer patients in MTFs. It is designed to track treatment by user hospitals. This is currently the only clinical summary information available in DEERS.

3.3 Specific Roles in Redesigned DEERS

3.3.1 Person Role

An individual exists within redesigned DEERS first and foremost as a *person* who may have multiple roles, including but not limited to: a sponsor, a family member, a beneficiary, and a patient. This implies the existence of certain attributes tied to a person that do not normally change as his or her role within the system changes. For example, a person has a name, date of birth, weight, height, hair color, eye color, and possibly an SSN. Both sponsor and family member are possible roles of a person in the redesigned DEERS database. The family member role is supported by person association and condition data that cross-references the family member's sponsor. This expanded person role exists solely within redesigned DEERS.

3.3.2 Sponsor and Family Member Roles

A sponsor is any person who, as a direct affiliate or member of an organization within the DoD, is entitled to benefits from the DoD and who, through that affiliation or membership, entitles his or her family members (formerly known as dependents) to benefits. Members of non-DoD organizations whose employees are authorized DoD benefits are also sponsors, and often accord eligibility to their family members. A sponsor's unremarried former spouse is not a sponsor and, therefore, cannot bestow benefits to any family members. The role of sponsor and family member within redesigned DEERS mirrors the roles within the current DEERS.

DoDI 1000.13 *Identification (ID) Cards for Members of the Uniformed Services, Their Dependents, and Other Eligible Individuals* defines which relationships to sponsors make individual family members eligible for benefits. Some restrictions that influence the definition of a child family member include age, degree of support by the sponsor, physical disability, and educational status.

3.3.3 Beneficiary Role - Multiple Entitlements/Dual Eligibility

Redesigned DEERS considers both sponsors and family members as beneficiaries (i.e., recipients of DoD benefits). The role of beneficiary is, however, ambiguous because a person may be entitled to DoD benefits via his or her simultaneous association to more than one sponsor. For example, a person may be a family member in two sponsored families at the same time. This situation occurs when both spouses in a family are sponsors. This condition is known as *multiple entitlements*. The beneficiary role exists within the current DEERS. However, redesigned DEERS supports additional capability for tracking multiple entitlements.

Entitlement periods may be sequential, such as when a son or daughter of a sponsor joins a Uniformed Service and he or she becomes a sponsor. Becoming a sponsor terminates the individual's previous eligibility for benefits as a family member.

In some cases, the roles leading to multiple entitlements may change back and forth. For example, a child of married reservists who move in and out of active duty assignments may have transitory periods of entitlement to medical benefits. Each sponsor in this family has the potential to provide medical benefits for the family member (child) for various periods of time. Therefore, this multiple-entitled child may need to be changed back and forth between the two sponsor spouses as the situation changes. The family member's eligibility thus requires continuous monitoring.

The concept of *dual eligibility* occurs when multiple entitlements are concurrent. This situation can occur when a sponsor is both a retired sponsor and a civil servant on overseas assignment. The beneficiary would have a coverage plan as the retired sponsor and another coverage plan as the civil servant. Hence, dual eligibility results when a person is associated with more than one DoD affiliation.

3.3.4 Patient Role

The patient role results from an association between a person and a DoD health care delivery system. It is important to note that a person is not required to be currently eligible for DoD benefits to be considered a patient. For example, the patient may have been a beneficiary in the past but is no longer eligible for DoD benefits. In certain cases, an individual who is not an authorized DoD beneficiary may be treated in an emergency situation at a DoD MTF, and is therefore a patient. The patient role does not exist within the current DEERS. However, the patient role exists within redesigned DEERS.

3.3.5 Beneficiary Roles Within Health Care Delivery Programs

3.3.5.1 Subscriber Role

A subscriber is an individual who is the primary holder of a DoD "policy" (i.e., the primary holder of a DoD entitlement) for health care benefits based on his or her affiliation with the DoD. The subscriber is the sponsor with one exception, that of the sponsor's unremarried former spouse, as legally defined by applicable legislation. Qualifications for unremarried former spouse status include length of marriage and other criteria. Unremarried former spouses are eligible in their own right, thus making them a subscriber.

The subscriber role does not exist within the current DEERS. However, the subscriber role exists within redesigned DEERS.

3.3.5.2 Insured Role

An insured is an individual who is covered by a Uniformed Services health benefits program (i.e., an HCDP) for medical or dental coverage. The individual is entitled to these programs based upon his or her association to a subscriber. A person may be both a subscriber and an insured. For example, under TRICARE Prime Individual Coverage for Retired Sponsor and Family Members, the sponsor is both the subscriber and an insured. An unremarried former spouse can also be both the subscriber and an insured. Additionally, a person may be a subscriber and not be an insured. For example, a sponsor on active duty may be the subscriber for his or her family members that are insured under TRICARE USFHP. The insured role does not exist within the current DEERS. However, the insured role exists within redesigned DEERS.

3.3.6 Sponsor, Subscriber, Beneficiary, and Insured Roles

As stated above, a sponsor is first and foremost, a person within redesigned DEERS. Figure 1 below details the association of a person, a sponsor, a subscriber, a beneficiary, and an insured. As a sponsor, the person may also be the subscriber who holds the DoD "policy" for health care benefits. As a beneficiary, the person may also be an insured who is covered by a DoD "policy" for health care benefits.

Figure 1. Relationships Among the Multiple Roles of a Sponsor

3.3.7 Family Member, Beneficiary, and Insured Roles

As stated previously, a family member is first and foremost, a *person* within redesigned DEERS. Figure 2 depicts the association of one person as a sponsor, and a second person as a family member, a beneficiary, and an insured. As a sponsor, the person may also be the subscriber who holds the DoD "policy" for health care benefits. Another person, through associations and relationships, may be a family member to the sponsor, which implies a role as a beneficiary. As a beneficiary, the person may also be an insured who is covered by a DoD "policy" for health care benefits.

Figure 2. Relationships Among the Multiple Roles of a Family Member

3.4 Terminology Used in the Commercial Health Insurance Industry

As a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation, the DoD, MHS and DEERS are migrating to a design based on commercial practices and standards for EDI based on ANSI ASC X12 and ANSI ASC HL7. DMDC is

modeling the solution for redesigned DEERS on a commercial health insurance concept and terminology.

3.4.1 Plan Sponsor

The plan sponsor is the organization or entity responsible for funding the coverage contained within the insurance plan. Within MHS, the DoD is the plan sponsor.

3.4.2 Insurer

The insurer is the insurance company(s). For redesigned DEERS, the DoD is the insurer (i.e., self-insured).

3.4.3 Insurance Program

The insurance program is the collection of insurance plans, offered by the plan sponsor, that make up the benefit structure for the beneficiary population.

3.4.4 Insurance Plans

The insurance plans are the individual benefit packages offering coverage for the beneficiary. For the DoD, this includes a medical benefit plan, a dental benefit plan, and a life insurance plan. For redesigned DEERS, the insurance plans are referred to as Health Care Delivery Programs (HCDPs). Refer to Section 3.5 for more details.

3.4.5 Insurance Plan Options

Insurance plan options represent the different types of coverage available within each insurance plan. For redesigned DEERS, insurance plan options are called HCDP Coverage Plans. Some examples of coverage plans include TRICARE Prime Individual Coverage for Active Duty Sponsors, TRICARE Prime Family Coverage for Transitional Assistance Family Members, and TRICARE USFHP Family Coverage for Active Duty Family Members.

3.4.6 Insurance Policy

An insurance policy is the unique insurance plan option selected by the beneficiary for each available insurance plan.

3.4.7 Subscriber

A subscriber is the individual who is the primary holder of an insurance policy. For redesigned DEERS, the subscriber is usually the sponsor. The exception to this is the Unremarried Former Spouse (URFS), who is also a subscriber.

3.4.8 Insured

The insured is the individual person covered under the insurance policy. For redesigned DEERS, the insured is the beneficiary.

3.5 Types of Health Care Delivery Programs and Plans

Delivery programs are methods of providing basic health and dental benefits. Coverage under these programs may be either individual or family, depending on the number of beneficiaries enrolled and beneficiaries' affiliation to the sponsor. Currently within DEERS, these are the basic HCDP types:

- Uniformed Services Health Benefit Programs
- Uniformed Services Dental Benefit Programs

The Uniformed Services Health Benefit Program consists of various health care coverage plans. Appendices C and D provide further details for the different health care coverage plans as viewed by DEERS.

Dental benefit program information is contained in the Dental Interface Operational Description.

3.5.1 Uniformed Services Health Benefit Program

3.5.1.1 Health Care Plan: Active Duty – Direct Care

The Active Duty (AD) - Direct Care (DC) health care delivery program is the basic coverage assigned by DEERS for eligible beneficiaries, namely active duty sponsors. The following coverage plan under Active Duty - Direct Care is available to appropriate beneficiaries:

- Direct Care for Active Duty Sponsors

3.5.1.2 Health Care Plan: Active Duty – TRICARE Remote

The 1998 National Defense Authorization Act requires medical care coverage for active duty members of the armed forces assigned to remote locations. The medical care coverage for remote locations is the coverage under the TRICARE Remote Program.

Eligibility for this health care coverage requires that the active duty service member's permanent duty location and residence be more than 50 miles from a Military Treatment Facility (MTF) or designated clinic. Under this program, the active duty service member may enroll and select a civilian Primary Care Manager (PCM); however, in some locations PCMs are not available.

Since the TRICARE Remote enrollment does not require a PCM, DEERS does not designate this program as a *Prime* health care delivery program. Additionally, TRICARE utilization review and utilization management requirements are not applied to this program; and designated Service Points of Contact (SPOCs) may authorize care not normally covered under the TRICARE Prime Uniform Benefit Program. Upon leaving the remote assignment, the active duty service member will remain enrolled in the TRICARE Remote Program until the service member changes his or her enrollment election. Currently, there is no policy requiring the active duty service member to change the

program enrollment upon leaving the remote assignment. The following coverage plans under TRICARE Remote are available to appropriate beneficiaries:

- TRICARE Remote for Active Duty Sponsors

3.5.1.3 Health Care Plan: TRICARE Standard

TRICARE Standard health care delivery program is the basic coverage assigned by DEERS for eligible beneficiaries. The following coverage plans under TRICARE Standard are available to appropriate beneficiaries:

- TRICARE Standard for Active Duty Family Members
- TRICARE Standard for Survivors of Active Duty Deceased Sponsors
- TRICARE Standard for Retired Sponsors and Family Members
- TRICARE Standard for Transitional Assistance Sponsors and Family Members

Note: The coverage plans above include survivors and unremarried former spouses of both active duty and retired sponsors.

3.5.1.4 Health Care Plan: TRICARE Extra

This plan allows a beneficiary eligible for the TRICARE Standard option to seek care from a TRICARE Extra network provider, thus obtaining a discount on services and a reduced cost share. Since TRICARE Extra acts like TRICARE Standard for DEERS purposes, DEERS does not track this option.

3.5.1.5 Health Care Plan: Direct Care

This plan allows beneficiaries, who are not entitled to civilian health care, to obtain care in military treatment facilities. Examples of the eligible population include dependent parents and parents-in-law, and those retired sponsors over the age of 65 who are eligible for the Medicare benefit. The following coverage plans under Direct Care are available to appropriate beneficiaries:

- Direct Care for Active Duty Family Members
- Direct Care for Retired Sponsors and Family Members
- Direct Care for Transitional Assistance Family Members

3.5.1.6 Health Care Plan: TRICARE Prime

Beneficiaries who are eligible for TRICARE Standard may elect to enroll into TRICARE Prime, which is similar to commercial Health Maintenance Organization (HMO) coverage. Beneficiaries must enroll through an authorized enrolling organization. Beneficiaries then select or are assigned a PCM, and under some coverage plans may pay an annual fee for coverage. The following coverage plans are available to appropriate beneficiaries under TRICARE Prime:

- TRICARE Prime Individual Coverage for Active Duty Sponsors
- TRICARE Prime Individual Coverage for Active Duty Family Members
- TRICARE Prime Family Coverage for Active Duty Family Members
- TRICARE Prime for Survivors of Active Duty Deceased Sponsors
- TRICARE Prime Individual Coverage for Retired Sponsors and Family Members
- TRICARE Prime Family Coverage for Retired Sponsors and Family Members
- TRICARE Prime Individual Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE Prime Family Coverage for Transitional Assistance Sponsors and Family Members

Note: The TRICARE Prime coverage plans listed above include survivors and unremarried former spouses of both active duty and retired sponsors.

3.5.1.7 Health Care Plan: TRICARE Remote

The OASD (HA) may extend the remote medical coverage provisions of the 1998 National Defense Authorization Act to family members of the active duty service members assigned to remote regions.

Eligibility for this health care coverage requires that the active duty service member's permanent duty location and residence be more than 50 miles from an MTF or designated clinic. Under this program the family members may enroll and select a civilian PCM; however, in some locations PCMs are not available.

As mentioned previously, DEERS will not designate this program as a *Prime* health care delivery program, since the program does not require the selection of a PCM.

Enrollment into the TRICARE Remote Program will not constitute entitlement to TRICARE Prime care. There will be no Point of Service (POS) option under this program. In addition, TRICARE utilization review and utilization management requirements are not expected to be applied to this program. Upon leaving the remote assignment, the family members will have to disenroll from the TRICARE Remote Program and may then enroll into the TRICARE Prime Program. If implemented, the plans available under this program will be:

- TRICARE Remote Individual Coverage for Active Duty Family Members
- TRICARE Remote Family Coverage for Active Duty Family Members

Appendix C and Appendix D currently show these plans as available options. If TRICARE Remote coverage is not extended to the family members of active duty sponsors, DEERS will not implement the plans listed in this section.

3.5.1.8 Health Care Plan: TRICARE Senior Prime

Beneficiaries who are eligible for Direct Care as well as Medicare may choose to enroll into the TRICARE Senior Prime coverage plan demonstration. Enrollees in this program must select a PCM in a participating MTF and are currently enrolled for the longevity of

the program rather than for a 12-month period. Enrollment fees do not apply to this program. TRICARE Senior Prime does not offer a family coverage plan; it is the only coverage plan that allows more than one individual plan for a family. Eligible beneficiaries may enroll into the following coverage plan:

- TRICARE Senior Prime Individual Coverage for Retired Sponsors and Family Members

3.5.1.9 Health Care Plan: TRICARE Uniformed Services Family Health Plan (USFHP)

The Uniformed Services Family Health Plan (USFHP) is a TRICARE program for major medical health care, preventive care, and medically necessary care including prescription drug coverage. Previously most of the USFHP facilities were part of the Uniformed Services Treatment Facilities (USTF) network created by Congress in 1981. The USFHP is currently composed of civilian health care facilities contracted by the DoD to provide health care through the USFHP program. The health care plans available through the USFHP program are:

- TRICARE USFHP Individual Coverage for Active Duty Family Members
- TRICARE USFHP Family Coverage for Active Duty Family Members
- TRICARE USFHP Individual Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Family Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Individual Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE USFHP Family Coverage for Transitional Assistance Sponsors and Family Members

Note: The coverage plans above include survivors and unremarried former spouses of both active duty and retired sponsors.

3.5.1.10 Health Care Plan: Federal Employees Health Benefits Program (FEHBP)

The FY 1999 National Defense Authorization Act directed the DoD and the Office of Personnel Management (OPM) to develop a demonstration project to allow Medicare eligible military retirees age 65 and over, their family members, certain unremarried former spouses of military members or former members, and family members of deceased military members or former members to enroll into an FEHBP Coverage Plan for their health care.

The FEHBP demonstration project will last for three years at eight demonstration sites. Health care coverage will begin January 1, 2000 and end December 31, 2002. Enrollment will be managed through the FEHBP Demonstration Project Information Processing

Center. The eligibility criteria and program requirements are beyond the scope of this document. However, the following plans will be available to the eligible community:

- Federal Employees Health Benefits Program (FEHBP) Individual Standard Coverage
- Federal Employees Health Benefits Program (FEHBP) Family Standard Coverage
- Federal Employees Health Benefits Program (FEHBP) Individual High Coverage
- Federal Employees Health Benefits Program (FEHBP) Family High Coverage

3.5.1.11 Health Care Plan: Continued Health Care Benefit Program (CHCBP)

The CHCBP is optional coverage to which beneficiaries may subscribe for a specified period (not to exceed 36 months) after the sponsor's entitlement to DoD benefits ends. The following coverage plans are available under CHCBP to appropriate beneficiaries:

- Continued Health Care Benefit Program Individual Coverage
- Continued Health Care Benefit Program Family Coverage

3.5.1.12 Health Care Plans for Department of Defense (DoD) Affiliates

Department of Defense (DoD) affiliates are a conglomerate category of individuals entitled to Direct Care or Civilian Health Care at different levels than the groups defined in other health care delivery programs. The currently defined compositions of the Direct Care categories are:

- Health Care Plan: Direct Care CONUS for DoD Affiliates

  This health care plan is available for the following population(s):

  - NATO Sponsored, Partnership for Peace, and NATO Non-sponsored Foreign Military and their Family Members
  - Non-NATO Sponsored Foreign Military and their Family Members

- Health Care Plan: Direct Care OCONUS for DoD Affiliates:

  This health care plan is available for the following population(s):

  - NATO and Non-NATO Foreign Military and their Family Members
  - Civilian Personnel of DoD and other government agencies and their accompanying family members
  - Civilian contractors under contract to the DoD or the Uniformed Services
  - Uniformed and non-uniformed full-time personnel of the Red Cross and their family members
  - Area executives, center directors and assistant directors of the USO and their family members

- United Seaman's Service (USS) personnel and their accompanying family members
- Military Sealift Command (MSC) Civil Service personnel

- Health Care Plan: TRICARE Standard CONUS for DoD Affiliates

  This health care plan is available for the following population(s):

  - Family Members of Sponsored and Non-sponsored NATO Foreign Military

3.5.2 Special Health Care Programs

DEERS will support any special health care programs mandated by the DoD. These special health care programs are programs into which a beneficiary can enroll, regardless of other assigned or enrolled health care coverage plans to which they are entitled. Currently, the only health care special program that DEERS supports is BRAC pharmacy. If the beneficiary has chosen BRAC pharmacy coverage, this information will be shown along with the begin date of the BRAC pharmacy coverage. Currently, BRAC information is returned only in the Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity Response. If the DoD adds any other special health care programs in the future, DEERS will incorporate these as appropriate.

3.6 Identification Schemas for Electronic Data Interchange

3.6.1 Primary and Secondary Identifiers

Identification of persons in the redesigned DEERS database happens via primary identifiers and secondary identifiers. A primary identifier must be unambiguous, so that information systems and software can process it without the need for intervention by users or artificial intelligence technology. Secondary identifiers can be ambiguous, and must be processed by users who match these secondary identifiers to persons in the redesigned DEERS database. Because secondary identifiers are ambiguous, system users generally use more than one secondary identifier in the identification process to minimize mistakes. More information on primary and secondary identifiers is explained in the next section of this document.

3.6.2 Person Identification

Sources external to DEERS identify persons initially in the DEERS database using only secondary identifiers. The secondary identifiers are:

- Social Security Number (SSN)
- First three characters of the last name
- Date of birth

If only the SSN is provided, duplicate records must often be resolved manually and thus system-to-system identification cannot be done. The last name and date of birth are used

to resolve duplications when two or more individuals have the same SSN, and to correct inaccurate identification of persons caused by using only the SSN. Usually, a person may be positively identified by an end user by matching an SSN along with the first three characters of the last name and the date of birth. Data for both sponsors and individual family members may be accessed in this manner.

Since redesigned DEERS does not contain every family member's SSN, the user may access these individuals by using the sponsor's secondary identification information. This will return a list of each family member associated with the sponsor.

3.6.3 Beneficiary Identification

Beneficiaries in the redesigned DEERS database are positively identified using a system-generated DEERS Identifier (DEERS Id). DEERS Ids are internal to DEERS and its interface systems, and therefore are not entered by users. Each DEERS Id is a primary identifier, and formed by a combination of the following:

- Family Identifier (Family Id), a DEERS-assigned nine-digit number unique to each family; along with a
- Beneficiary Identifier (Beneficiary Id), a DEERS-assigned two-digit number unique to each individual in a family

Although a person may have more than one DEERS Id, stemming from multiple entitlements (defined previously), DEERS Ids positively identify each beneficiary. DEERS Ids, therefore, serve as *primary identifiers* and are used by information systems when passing EDI data about individual beneficiaries and families.

A person may have multiple DEERS Ids over time and some of these instances are described as follows:

- A person may be entitled to DoD benefits via his or her association to more than one sponsor simultaneously. For example, a person may be a family member in two sponsored families at the same time. This situation occurs when both spouses in a family are sponsors. This condition is known as *multiple entitlements*.
- Entitlement periods may be sequential, such as when a son or daughter of a sponsor joins a Uniformed Service and he or she becomes a sponsor. In this case, the person would have a DEERS Id as a family member *and* as a sponsor. However, becoming a sponsor terminates the individual's previous eligibility for benefits as a family member.

Dual eligibility occurs when multiple entitlements are concurrent. In this situation, the person only has one DEERS Id with multiple entitlements, because they are associated with more than one DoD affiliation.

3.6.4 Patient Identification

Patients will have a primary identifier called the Patient Identifier (Patient Id), which will also be a DEERS-assigned nine-digit number. This will be used similarly to the DEERS

Id, although the primary purpose is to reliably access patient information. DEERS will generate a Patient Id as an interim solution until the new national patient identifier, referred to as the HIPAA Master Patient Id (MPI), resulting from HIPAA legislation, becomes available. The HIPAA MPI needs additional analysis before its implementation into redesigned DEERS.

3.6.5 HCDP Enrollment Fee System Identification

HCDP Enrollment Fee Systems are entities that collect and maintain enrollment fee information. These systems are also responsible for communicating enrollment fee payment information to DEERS. Currently, only MCSC organizations are responsible for collecting enrollment fees. DEERS will record the systems that send enrollment fee information for a policy. Each system represents a physical MCSC system corresponding to a region and will be used for routing notifications from DEERS. DEERS will create the system identifier and distribute the identifier to each system.

3.6.6 HCDP Enrollment Management System Identification

HCDP Enrollment Management Systems are entities that are authorized to enroll MHS-eligible sponsors and family members into DoD coverage plans and are responsible for maintaining an individual's HCDP policy. The organizations include MCSCs and are referred to as *enrolling organizations*. These systems track enrollment anniversary dates and solicit information for re-enrollment activities for coverage plans requiring enrollment fees. DEERS will track the last system to update an individual's policy. A person will only have one enrollment management system that is responsible for managing their coverage at any given point in time. This system represents an MCSC system and will be used for routing notifications from DEERS. DEERS will create this system identifier and distribute the identifier to each system. Each MCSC system will have a system identifier for each region, not by contract.

3.6.7 PCM Enrolling Division System Identification

The PCM Enrolling Division System is the system responsible for maintaining specific PCM Enrolling Divisions. DEERS will derive this system identifier through the HCDP Enrollment Management System and the PCM Enrolling Division.

3.6.8 PCM Enrolling Division Identification

The PCM Enrolling Division is the organization that is primarily responsible for delivering the beneficiary's health care. This represents a grouping of providers in the Civilian, Direct Care, and TRICARE USFHP networks. Examples include MTFs, satellite clinics of MTFs, and possibly clinics within the MTF. DEERS will maintain a table of organizations into which eligible subscribers and family members are enrolled. These organizations will be identified by Defense Medical Information System (DMIS) Ids. DEERS will maintain the association between these organizations and the regions in which they are located.

3.6.9 PCM Identification

DEERS will use the PCM Id as an interim solution until a national provider identifier becomes available. At that time, DEERS will convert PCMs to this new identifier. The list of PCMs will be populated as DEERS receives the information from enrollment transactions. DEERS will create a list of all PCMs from this enrollment information.

3.6.10 Policy Identification

DEERS will use the following combination to identify a policy uniquely: DEERS Family Id, HCDP Type, and HCDP Plan Coverage Code. A sponsor can be a subscriber to multiple policies. In the case of an unremarried former spouse, that individual will be assigned a new and different DEERS Family Id from that of the sponsor. The unremarried former spouse will become both the subscriber and insured and will represent his or her own family and policy.

3.6.11 Nonavailability Statement Identification

The Nonavailability Statement (NAS) Id is generated by DEERS and is used to identify the NAS uniquely. The NAS Id is composed of the NAS Issuing Facility Id, which corresponds to the DMIS Id; date of issuance; and type of issuance.

3.6.12 Person Identification for Business Events

The following table identifies the options and type of data necessary to perform a DEERS/Medical business event.

Legend (an "X" in a column indicates that the information may be used):

- Person information: includes the Person Id and Person Id Type Code, along with last name and date of birth. Last name and date of birth are optional, but recommended to ensure correct person identification
- Individual/Family: indicates if the business event can be done for an individual, a family, or both

Refer to the specific business events throughout the IOD and in Appendix F, Business Rules Matrix for additional information.

Person Identification for Business Events				
Person Information	**DEERS Id**	**Patient Id**	**Individual/ Family**	**Business Event**
X			I, F	General Health Care Coverage Inquiry
X		X	I, F	Health Care Coverage Inquiry for MTF
X	X		I, F	Eligibility for Enrollment Inquiry
	X		I	Enrollment
	X	X	I	Enrollment Notification
	X (sponsor's)		I	Add a Newborn Beneficiary to DEERS from Enrolling Organization
		X (sponsor's)	I	Add a Newborn Beneficiary to DEERS from MTF
	X		I	Re-enrollment
	X		I	Disenrollment – Loss of Eligibility
	X		I	Disenrollment – Voluntary or Involuntary
	X		I	PCM Change
	X		I	PCM Cancellation
	X		I	Transfer Enrollment/Portability
	X		I	Change an Individual's Enrollment Period
	X		F	Change a Family's Enrollment Period
	X		I	Change Enrollment End Reason Code
	X		I	Cancel Enrollment/ Disenrollment
			I	Enrollment Fee Payment
	X		Policy	Enrollment Fee Payment Transaction History Request
	X		I	Update Individual Enrollment Fee Waiver Information
	X		I	Beneficiary Updates
X			I	Patient Add
		X	I	Patient Updates
X	X		I, F	Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity
	X		I	Catastrophic Cap & Deductible Totals Inquiry
	X		I	Catastrophic Cap & Deductible Updates

Person Identification for Business Events				
Person Information	**DEERS Id**	**Patient Id**	**Individual/ Family**	**Business Event**
X	X		I, F	Catastrophic Cap & Deductible Transaction History Request
X	X	X	I	NAS Inquiry
		X	I	NAS Issuance
		X	I	NAS Cancellation
	X	X	I	OHI Inquiry
	X	X	I	OHI Policy Add/Update
	X	X	I	OHI Cancellation

3.7 The National Enrollment Database and Enrollment-Based Capitation Tracking

A satellite database of DEERS, the National Enrollment Database (NEDB), will support a portable Uniformed Services health benefits program by centralizing all enrollment and eligibility data. All TRICARE enrollment transactions will be sent to DEERS NEDB. DEERS will track active duty TRICARE enrollment information indefinitely. The primary mission of the NEDB is to provide a single source for TRICARE enrollment information. The NEDB makes benefits portable for beneficiaries on a global basis. Additionally, as the MHS migrates toward basing its finance policy on Enrollment-Based Capitation (EBC), accurately tracking enrollment information becomes critical, since each MTF receives a per-member, per-month premium for each enrollee.

DEERS proposes the following mechanisms to track enrollments for DoD HCDPs:

- TRICARE Region — A DoD-defined geographic location where the uniform TRICARE benefit is offered. TRICARE Region is referred to as the PCM Region Id in redesigned DEERS.
- Provider Organization — A network of PCMs within a specific TRICARE Region. There are three potential provider organizations within each region: Direct Care Providers, the Civilian Provider Network, and the TRICARE USFHP provider network. Provider Organization represents PCM Location in current DEERS and is referred to as the PCM Network Provider Type Code in redesigned DEERS.
- Provider Location — The location where a PCM provides care. To date, this is the most specific data DEERS reports to support EBC. Provider location represents the DMIS code in current DEERS and is referred to as the PCM Enrolling Division DMIS Id in redesigned DEERS.

- PCM — The individual or group responsible for delivering primary health care. A unique PCM identifier will identify each PCM. Eventually, the HIPAA-defined standard Provider Id will replace this. PCMs can be in one of the following networks, Direct Care, Civilian, or TRICARE USFHP. For PCMs in the Civilian, Direct Care and TRICARE USFHP networks, the following information is tracked by redesigned DEERS:
  - PCM Region, PCM Network Provider Type Code (PCM Affiliation), PCM Enrolling Division DMIS Id, PCM Id and type code
  - PCM Selection Begin/End Date
  - PCM Selection End Reason Code, if applicable
  - If a PCM is within the civilian network, DEERS will make the provision to store the ZIP code and country code. However, this data is not required for civilian PCMs.
- TRICARE Provider/Region Relationship — A PCM is affiliated with a TRICARE Provider Organization. Additionally, a PCM has a TRICARE Provider Location, which indicates where they work. This location is geographically located within a specific TRICARE Region.

  DEERS will only store one occurrence of the TRICARE Provider/Region Relationship for each PCM Id.

The following diagram shows the relationship between the Provider Location and the TRICARE Region.

Figure 3. Enrollment-Based Capitation (EBC)Tracking: Provider Location and TRICARE Region

4 Interface Overview

4.1 Background, Objectives and Scope

The X12 and HL7 interfaces meet HIPAA requirements. Both are non-proprietary formats and reduce costs by using commercial-off-the-shelf (COTS) software, which also increases system flexibility.

4.2 Operational Policies and Constraints

DEERS and its interfacing systems will operate under the following policies and constraints:

- DEERS and its interfacing systems will incorporate standard Provider, Payer, and Patient Ids, as legislated under HIPAA
- In compliance with HIPAA legislation, organizations, including MCSCs, requesting information about eligibility, enrollment, and claims catastrophic cap and deductible data will communicate with DEERS using ANSI ASC X12
- Clinically focused organizations, including CHCS facilities, will use ANSI ASC HL7 for clinically related events
- All systems, including DEERS, will use DISN for the communications infrastructure

4.3 System Description

4.3.1 DEERS Operational Environment and Characteristics

The DEERS system environment consists of a relational database management system (RDBMS); rules-based applications (i.e., knowledge bases) processing DoD entitlements and eligibility; and a Transmission Control Protocol/Internet Protocol (TCP/IP) sockets listener.

4.3.2 DEERS Major System Components

Major components of redesigned DEERS include:

- Person repository
- Patient repository
- Enrollment history repository
- Interface engine
- National Enrollment Database
- Centralized catastrophic cap & deductible repository

4.3.3 External Systems

4.3.3.1 Interface

DEERS will use the DISN as its communications network.

DEERS will interact with the external systems via its interface engine (IE), which is responsible for message translation and routing in support of the EDI HL7/X12 standards.

Major MHS communities that DEERS interfaces with include:

- Composite Health Care System (CHCS)
- DoD service personnel systems
- MHS clinical systems
- MHS Corporate Executive Information System (CEIS)
- Managed care support contractors (MCSCs)/claims processors
- TRICARE USFHP, formerly known as Uniformed Services Treatment Facilities (USTF)
- Health benefits advisors and other users throughout the CONUS and OCONUS via the Government Inquiry of DEERS (GIQD) application
- Base Realignment and Closure (BRAC) pharmacy benefit program contractors
- Continued Health Care Benefit Program (CHCBP) administrator
- National Mail Order Pharmacy contractor
- Other organizations as identified

4.3.3.2 Data Sequencing

Since DEERS is tasked with resolving data conflicts from external systems using rules-based applications, DEERS expects that proper data sequencing will be the responsibility of the external system. This will aid in maintaining data validity and integrity.

4.3.4 System Diagrams and Descriptions

Figure 4. DEERS MHS Process Model

Figure 5. External Interface Diagram

5 Redesigned DEERS Functions

DEERS will provide two views of benefits and entitlements information: Eligibility for Enrollment and Coverage.

The DEERS interface supports requests for beneficiary entitlement and eligibility information in accordance with DoD Initiatives, currently DoDI 1000.13. Replies to this type of inquiry will contain detailed information regarding a beneficiary's entitlement and eligibility to receive DoD medical and dental benefits. This event may be triggered by requests for enrollment, registration within an MTF, claims processing requests, appointment scheduling, and general coverage requests.

The benefits and entitlements for which a person may be eligible include either Civilian Health Care (meaning care delivered by a civilian health care provider, with costs-shared by the DoD) or Direct Care, which is delivered at a DoD MTF and includes eligibility to enroll into a dental program.

5.1 Duplicate Person Identification

Person identification is done using the Person Id (SSN, Foreign National Id, or Temporary Id), the DEERS Id, or the Patient Id. If the request uses the Person Id, this request should also provide the person's last lame and date of birth. The request can also specify whether the inquiry is for an individual or for the individual and associated family members, if any. For family inquiries, the Person Type Code (sponsor or family member) must also be provided. Person identification applies to sponsors and family members.

The person identification information is used when the DEERS Id or Patient Id is not available. For example, this request would be used the first time the sending organization requested information on the person. If the SSN is neither duplicated in the DEERS database nor connected to DoD benefits by more than one person (Beneficiary Id), then the DEERS Id, the Patient Id, or possibly both, will be returned along with the rest of the information requested for the inquiry.

Person ambiguity can occur when two or more persons have the same SSN within DEERS. As mentioned previously with multiple entitlements, a person's role within DEERS may change over time, meaning he or she may be both a family member and a sponsor. Therefore, DEERS uses the Person Type Code (sponsor or family member) to identify the role the person is representing in the family inquiry to search for the person. If the request uses the SSN of the sponsor, DEERS will conduct the search where the SSN is used for a person representing a sponsor. If DEERS determines that the SSN is associated with multiple sponsors, DEERS will provide a partial match response. Likewise, if the request uses the SSN of a family member, DEERS will conduct the search where the SSN is used for a person representing a family member. If DEERS determines that the SSN is associated with multiple family members, DEERS will provide a partial match response.

If there is ambiguity, then a partial match response will be returned. There will be a separate listing for each person or family matching the requested SSN. The listing will

include the sponsor and family member identification information needed to determine the correct beneficiary or family including the DEERS Id, the Patient Id, or possibly both. The requesting organization must select which of the multiple listings is correct based on documents or information at hand. After this selection, the requester would use the DEERS Id or Patient Id of the person or family chosen to send the inquiry. A partial match response may be returned for any inquiry that does not use a DEERS Id or Patient Id.

If the request uses the DEERS Id, Patient Id, or the Person Id when it is only associated with one person, DEERS will be able to identify the individual positively and return the person, eligibility and coverage information for both the person and family, if any. Using the DEERS Id or Patient Id in an inquiry always provides an unambiguous match.

An illustration of a multiple person match is provided in the following diagram.

Figure 6. Partial Match Response from an Inquiry

5.2 Health Care Coverage

DEERS centrally stores eligibility and enrollment information regarding a beneficiary's health care coverage. This information is maintained over time and identifies specific health care coverage at a specific point or period in time. There are several purposes for inquiring about a beneficiary's health coverage including verifying coverage for customer service requests, making clinical appointments, and updating catastrophic cap and deductible amounts. Each of these different functions is presented separately and the information is tailored toward the intention of the business. The identified areas include general health care coverage and clinical health care coverage.

5.2.1 General Health Care Coverage Inquiry

5.2.1.1 Information Required for a General Coverage Inquiry

5.2.1.1.1 Person Identification for a General Coverage Inquiry

A beneficiary's coverage information is accessed using the Person Id (SSN, Foreign National Id, or Temporary Id), last name, and date of birth (last name and date of birth are optional but recommended).

5.2.1.1.2 Inquiry Options: Person or Family

The inquirer must specify if the coverage inquiry is for a person or the entire family. The person inquiry option should be used when specific person identification is known. If person information is incomplete, the family inquiry mode can be used. In family inquiries, the Person Type Code is required to indicate if the SSN, Foreign Id, or Temporary Id is for the sponsor or family member. For family inquiries, DEERS will return both sponsor and family member information. If the request is for data on a person and includes the person identification for the family member, DEERS will return coverage information only for the family member. If there is more than one person or family match, the correct person must be selected, then the coverage inquiry re-sent. Refer to the Duplicate Person Identification section for more information.

5.2.1.1.3 Inquiry Period

In addition to identifying the correct person or family, the inquirer must supply the inquiry period. The inquiry period may either be a single day or span multiple days. Historical dates are valid, as long as the requested dates are within three years of loss of eligibility. The inquirer queries DEERS for information about the coverage plans in effect during that inquiry period for the sponsor and/or family member. The reply may include one or more coverage plans in effect during the specified period or contain no coverage plan, meaning the beneficiary was ineligible for benefits for the specified time period.

5.2.1.2 Information Returned in the General Coverage Inquiry Response

For the period of the inquiry, the response to a coverage inquiry will include:

- Sponsor identification information, including name, personnel, etc.
- Family member information, including demographics
- Health care coverage information

5.2.1.2.1 Health Care Data Returned in a Coverage Inquiry That Repeats For Every Coverage Plan

In response to a coverage inquiry, DEERS returns the specified coverage information in effect for the inquiry period. The following list shows the information DEERS returns for each coverage plan in effect during the inquiry period:

- Coverage plan information (assigned or enrolled)

- Coverage plan enrollment status
- Coverage plan begin and end dates For inquiry period
- Sponsor personnel information (active duty, retired, pay grade, pay plan, etc.) and family member relationship to the sponsor during coverage period

5.2.1.2.2. Data Returned in a Coverage Inquiry Independent From the Coverage Plan Information

The DEERS coverage response could include Primary Care Manager, Other Health Insurance (OHI), Other Government Programs (OGP), and NAS information, independent from the health care coverage information. If no OHI, OGP, or NAS information is returned, this means that DEERS does not have this information in effect for the requested inquiry dates.

- Primary Care Manager information: PCM information will be returned for each coverage plan that has an enrollment. No PCM information is present for the DoD-assigned coverage plans.
- Other Health Insurance: Limited OHI information will be returned. To receive additional OHI information, the inquirer may send a separate OHI inquiry.
- Other Government Programs: Complete OGP information will be provided in the response. OGPs include CHAMPVA and Medicare.
- Nonavailability Statements: Limited NAS information will be provided in the coverage response. Both active and cancelled NAS information will be returned, if the NAS issue date was within the requested coverage dates. To receive additional NAS information, the inquirer may send a separate NAS inquiry.

5.2.1.3 Multiple Responses to a Single General Health Care Coverage Inquiry

DEERS may need to send multiple responses to a single health care coverage inquiry, and these responses will be returned in a single transaction. This situation could occur if a person has multiple DEERS Ids within the inquiry period. It is necessary for DEERS to capture family member entitlements and benefit coverage corresponding to each instance of the person's DEERS Id. For example, in a joint service marriage, a child may be covered by the mother from January through May (DEERS Id #1) and covered by the father from June through December (DEERS Id #2). The child should not have dual coverage under both the mother and the father concurrently.

The following diagram details the data elements within a General Health Care coverage Inquiry.

Figure 7. General Health Care Coverage Inquiry

5.2.2 Health Care Coverage Inquiry for Military Treatment Facilities

Coverage inquiry at an MTF will consist of an eligibility verification at the MTF, which is an inquiry for DoD Health Care represented by an assignment or enrollment into a health care delivery program that authorizes care through the Direct Care system. A coverage inquiry should be performed prior to scheduling clinical encounters for patients.

5.2.2.1 Information Required for a Coverage Inquiry for Military Treatment Facilities

5.2.2.1.1 Person Identification

The first time a beneficiary's or family's information is accessed for clinical events, the MTF must perform a coverage inquiry using person information including Person Id (SSN, Foreign National Id, or Temporary Id), Person Type Code (sponsor or family member), date of birth, and last name (last name and date of birth are optional but recommended).

Clinical organizations will use the Patient Id in a way similar to that of enrolling organizations using the DEERS Id to communicate with DEERS. The Patient Id will be included in DEERS' reply to the inquiry about the patient, provided any ambiguity about the patient's SSN is resolved. The Patient Id should be retained for use in all subsequent clinically-oriented interactions with DEERS. Thereafter, either Person Id information or the Patient Id can be used when performing MTF coverage inquiries.

5.2.2.1.2 Inquiry Options: Person or Family

Inquiries will generally use the person option for eligibility verification tied to a clinical event. The family option is also available to obtain complete coverage information for all family members. In family inquiries, the Person Type Code is required to indicate if the Person Id is for the sponsor or family member. For family inquiries, DEERS will return both sponsor and family member information. If the request is for data on a person and includes the person identification for the family member, DEERS will return coverage information only for the family member. If there is more than one person or family match, the correct person or family must be selected and the inquiry re-sent. Refer to the Duplicate Person Identification section for more information.

5.2.2.1.3 Inquiry Period

In addition to identifying the correct person or family, the inquirer must supply the inquiry period. The inquiry period may be a single day or span multiple days, and historical dates are valid, as long as the requested dates are within three years of loss of eligibility. The inquirer queries DEERS for information about the coverage plans in effect during that inquiry period for the sponsor and/or family member. The reply may include one or more coverage plans in effect during the specified period or contain no coverage plan, meaning the beneficiary was ineligible for benefits for the specified time period.

5.2.2.2 Information Returned in the Response to Coverage Inquiry for MTF

The response to a coverage inquiry for MTF will always include:

- The sponsor name and current personnel information
- Patient information including organ donor participation, blood type, and death information, if applicable
- The following sections will repeat for each coverage segment within the inquiry dates. Coverage segments are created when there is a change in any of the coverage factors below. Coverage information for the patient within the specified inquiry period will include the following:
  - Coverage and demographic information
  - HCDP coverage plan and policy information for the individual or family members, including subscriber status (active duty or retired), insured category, and relationship to the insured
  - Enrollment information for the individual or family member, if applicable
- PCM information for the insured (if PCM is applicable to the HCDP coverage plan)
- Limited data on OHI (e.g., commercial) effective during the inquiry period. To receive additional OHI information, the requester can send a specific OHI inquiry
- Complete data about coverage by OGP (e.g. Medicare) in effect during the inquiry period
- Limited NAS information if the issue date is within the inquiry period. To receive additional NAS data, the requester can send a specific NAS inquiry. Both active and cancelled NAS information will be returned, if the NAS issue date was within the requested coverage dates.

When an MTF sends a coverage inquiry for a period of time, the DEERS response will provide the health care coverage plans and health care coverage begin and end dates for all coverage plans in effect for the inquiry period.

An example of the type of information returned for a coverage inquiry for the period 1 August through 9 October is illustrated in the tables contained in the Health Care Coverage Copayment Factor for Coverage Inquiries section. If the requested coverage inquiry is for a range of dates outside eligibility for an assigned or enrolled health care coverage plan, a health care coverage segment will be returned showing not eligible for the period of the coverage inquiry outside the eligibility for the assigned or enrolled health care coverage plans.

The following diagram details the data elements within the health care coverage inquiry for MTFs.

Figure 8. Health Care Coverage Inquiry for MTFs

5.2.3 Health Care Special Programs for Coverage Inquiries

DEERS will return health care special program information if it is present for the inquiry period requested. Currently, BRAC pharmacy is the only health care special program in DEERS. If the beneficiary has chosen BRAC pharmacy, this information will be shown along with the coverage begin date.

5.2.4 Health Care Coverage Status for Coverage Inquiries

The Health Care Coverage (HCC) Enrollment Status Code indicates if the enrollment is within the grace period or beyond the grace period. Coverage inquiries will show the Health Care Coverage Enrollment Status of "in grace period" if the beneficiary is within the 30-day re-enrollment grace period and DEERS has not received a re-enrollment or disenrollment notification. If no re-enrollment transaction is received within the 30-day grace period, DEERS reflects the assigned coverage plan and there is no enrollment status. Eligibility for Enrollment Inquiries will automatically show the DEERS assigned coverage effective the day after an enrollment expires. Coverage inquiries will show the Health Care Coverage Enrollment Status of "beyond grace period" if the current date is within the 30-day re-enrollment period, but the inquiry period is after the grace period and DEERS has not received a re-enrollment or disenrollment notification. The following table illustrates the use of this enrollment status and the applicable situations for each value.

Current Date	Inquiry Period	Enrollment Status
In Grace Period	In Grace Period	In Grace Period
Outside Grace Period	In Grace Period	DEERS Assigned Coverage
Outside Grace Period	Outside Grace Period	DEERS Assigned Coverage
In Grace Period	Outside Grace Period	Beyond Grace Period

5.2.5 Health Care Coverage Copayment Factor for Coverage Inquiries

The copayment rate for an insured is determined using information provided by DEERS and may also include treatment information from a claim. The different factors are determined by legislation, which considers factors such as pay grade (E4 and below or E5 and above), and personnel category, such as retired sponsor or active duty.

The Health Care Coverage Copayment Factor Code is based on the copayment factor in effect on the enrollment begin date for enrolled plans. In other words, if the sponsor were promoted from E4 to E5 in the middle of an enrollment year, the E4 rate would remain in this field for the duration of the enrollment year. The new E5 rate would begin with the next enrollment period. However, the Health Care Coverage Pay Plan Code shows the current pay plan as it changes over time.

The current health care delivery program copayment rates are:

- Active duty E4 and below rate
- Active duty E5 and above rate
- Retiree rate

Note: More rate codes can be added, as required by the DoD.

Although the rates are based on the population to which they pertain, such as retired sponsor, these rates also apply to a sponsor's family members. For example, family members of a sponsor who dies on active duty will pay the active duty rate for one year following the date of death. After that, eligible family members will pay the retiree rate.

In addition, congressional legislation may effect deductibles and rates. The Special Entitlement Code will provide information to support this legislation. For example, when service members were mobilized and sent to Bosnia, their deductibles were waived.

An example of some of the information that DEERS will return in a coverage inquiry is illustrated below. In this example, the inquirer has sent a coverage inquiry for the inquiry period 1 August 1998 through 9 October 1998. In this example, the enrollment anniversary date is October 1. DEERS replies with the three sets of data shown in the following table.

Description	Period 1	Period 2	Period 3
Health Care Delivery Program Plan Coverage Code	TRICARE Prime	TRICARE Prime	TRICARE Prime
Health Care Coverage Copayment Factor Code	E4	E4	E5
Health Care Coverage Pay Plan Code	E4	E5	E5
Health Care Coverage Member Category Code & Member Relationship Code	Army active duty child	Army active duty child	Army active duty child
Time Period (Promotion effective 9/1)	Aug. 1 – Aug. 31	Sept. 1 – Sept. 30	Oct. 1 – Oct 9

Note: The HCC Copayment Factor Code remains E4 until October 1, which begins the next enrollment year. However, the HCC Pay Plan Code changes over time and is updated accordingly.

5.3 Health Care Delivery Program Eligibility and Enrollment

The rules for determining a beneficiary's entitlement to health care benefits are applied by rules-based software within DEERS. DEERS is the sole repository for these DoD rules, and no other eligibility determination outside of DEERS is considered valid. Whenever data about an individual sponsor or a family member changes, DEERS reapplies these rules. DEERS receives daily, weekly, and monthly updates to this data, which is why enrolling organizations must query DEERS for eligibility information before beneficiary activity. This insures that the individual is still eligible to use the benefits.

A beneficiary who is considered eligible for DoD benefits, according to DoDI 1000.13, is not required to "sign up" for the TRICARE Standard benefits. If an authorized organization inquires about that beneficiary's eligibility, DEERS will reflect if he or she is eligible to use the benefits. The effective and expiration dates for TRICARE Standard coverage are derived from DoDI 1000.13 rules and supporting information.

5.3.1 Enrollment-Related Business Events

There are several types of enrollment transactions:

- Eligibility for enrollment identifies current coverage plans and eligibility to enroll into other coverage plans.
- New enrollments are used for enrolling eligible sponsors and family members, including newborn beneficiaries, into HCDP coverage plans or for adding family members to an existing family enrollment. New enrollments may also perform the following functions:
  - Specify enrollment fee information
  - PCM selection
  - Notify DEERS that the enrollee has a new address or telephone number
  - Notify DEERS that the enrollee has other health insurance
- Re-enrollments are used for extending current enrollment for another 12-month term (or less, depending on eligibility).
- Modifications of the current enrollment (updates) are used to change some information in the current enrollment plan. Modifications of the current enrollment include the following functions:
  - Change or cancel a PCM selection
  - Transfer enrollment (enrollment portability)
  - Change enrollment begin or end date
  - Change enrollment end reason
  - Cancel enrollment/disenrollment

- Enrollment fee payments and enrollment fee waivers are used to indicate payment of, or exception from payment of, enrollment fees. The enrollment fee history transaction is used to view this detailed information for a specified policy.
- Disenrollments are used to terminate the specified beneficiary's enrollment. Disenrollments will be used for disenrolling a beneficiary only when he or she has lost eligibility,voluntarily disenrolls (e.g., chooses not to re-enroll) or involuntarily disenrolls (e.g., fails to pay enrollment fees).

5.3.2 Eligibility for Enrollment Inquiry

The DoD provides assigned health care delivery programs and plans when a person joins the DoD. DEERS also determines coverage plans for which a beneficiary is eligible to enroll by using the DoD-assigned coverage in conjunction with additional eligibility information. The Eligibility for Enrollment Inquiry is used to view a person's or family's eligibility.

Enrolling organizations use this inquiry prior to enrollment. DEERS will provide coverage plan information identifying the status (e.g., "assigned," "eligible for," "enrolled") along with the period of eligibility and/or enrollment for the coverage plan. A beneficiary can only be enrolled into the coverage plans that have an "eligible for" status. Refer to the Coverage Plan Status section for additional information on the status associated with a coverage plan. DEERS currently guarantees eligibility for enrollment only at the online, real-time point requested.

5.3.2.1 Information Required for an Eligibility Inquiry for Enrollment

5.3.2.1.1 Person Identification for Eligibility Inquiry for Enrollment

Eligibility verification is requested using either the Person Id (SSN, Foreign Id, or Temporary Id) or the DEERS Id. If the request uses the Person Id, it should also include the person's date of birth and last name (last name and date of birth are optional but recommended) to ensure that a unique person is accessed.

After an initial eligibility inquiry, the requesting organization should retain the person's correct DEERS Id for use in subsequent transactions, to update policy and enrollment information. The inquiring organization may continue to use the Person Id for eligibility inquiries prior to enrollment, if needed.

5.3.2.1.2 Inquiry Options: Person or Family

An eligibility inquiry can request information for either a person or a family. In family inquiries, the Person Type Code is required to indicate if the Person Id is for the sponsor or family member. For family inquiries, DEERS will return both sponsor and family member information. If the request is for data on a person and includes the person identification for the family member, DEERS will return eligibility information only for the family member. If there is more than one person or family match, the correct person or family must be selected and the inquiry re-sent. Refer to the Duplicate Person Identification section for more information.

When enrolling a person into an HCDP, (e.g., TRICARE Prime) only the person's identification information should be sent, using the person inquiry mode rather than the family inquiry mode. If the person is eligible, the enrolling organization can elect to perform the enrollment transaction for the individual.

When enrolling a family in an HCDP, (e.g., TRICARE Prime) the sponsor's or family member's identification information should be sent using the family inquiry mode. DEERS will return data on the sponsor as both a subscriber and an insured, as well as data on the family members as the insureds. If the family is eligible, the enrolling organization can elect to perform the enrollment transaction for each family member.

5.3.2.1.3 Inquiry Period

This eligibility inquiry may be made for the current date, a date 60 days prior to the current date to support retroactive enrollments, or a date up to 90 days in the future. The response to this inquiry will include all health care program coverage periods that were in effect within the last year of the inquiry date.

5.3.2.1.4 Health Care Delivery Program

The inquirer must specify the health care delivery program for which eligibility is requested. DEERS will respond with all current coverage information for the beneficiary and will only include the "eligible for" plans associated with the requested health care delivery program.

For example, if the inquirer specifies TRICARE Prime, DEERS will return the current coverage information and only the TRICARE Prime coverage plans for which the beneficiary is eligible to enroll.

5.3.2.2 Information Returned in the Eligibility for Enrollment Response

For the date of the inquiry, the response to an eligibility inquiry will always include:

- Subscriber level information
  - Personnel information for subscribers, if applicable.
  - Coverage plan enrollment information, including the enrollment anniversary date and the enrollment fee information for the specific HCDP policy. DEERS will return a coverage plan enrollment section for each coverage plan that requires an enrollment.
  - Family catastrophic cap totals information is returned when there is eligibility to enroll into a coverage plan that requires a fee payment. DEERS will determine when to return these totals and no locking of catastrophic cap information will be done at this time. Catastrophic cap accumulations are broken out by HCDP and are subdivided by the fiscal year and enrollment year, if applicable, to which they apply. This data is for information purposes only. Refer to the Enrollment and Catastrophic Cap and Deductible Data sections for additional information.
- Family member information, including demographics.

- Information for each insured:
  - HCDP coverage plan and policy information for the insured, including Civilian Health Care and Direct Care benefits and the status of the coverage plan.
  - Enrollment coverage information for the insured, if applicable. Enrollment fee waiver information associated with a beneficiary will also be returned. All enrollment coverage segments will be shown for the year preceding the inquiry date.
  - PCM information from the year preceding the inquiry date will be shown for the insured, if applicable for the HCDP coverage plan.
  - Limited information on OHI (e.g., commercial). To receive additional OHI information, the requester can send a specific OHI inquiry.
  - Complete information about coverage by OGP currently in effect, including Medicare and CHAMPVA.

Refer to the following diagram for details about what data is passed for eligibility transactions for enrollment.

Figure 9. Eligibility for Enrollment Inquiry

5.3.2.3 Multiple Responses to a Single Eligibility for Enrollment Inquiry

DEERS may need to send multiple responses to a single Eligibility for Enrollment Inquiry and these responses will be returned in a single transaction. This situation could occur if the sponsor is associated with multiple DoD affiliations, for example, a retired sponsor who is also a civil servant on an overseas assignment. Multiple personnel segments that exist concurrently represent the multiple entitlements condition and DEERS will capture each personnel segment corresponding to the associated DoD affiliation. In this situation, the sponsor has only one DEERS Id representing all entitlements and benefit coverage.

5.3.2.4 Coverage Plan Status

A beneficiary may have several associated coverage plans when eligibility for enrollment verification is performed by an enrolling organization. Each of the associated coverage plans may have a different status. Currently, DEERS has identified the following statuses for medical benefit coverage plans: assigned, eligible for, enrolled, or possibly a combination. A coverage plan status of "assigned" identifies the coverage and eligibility period a beneficiary is entitled to because of their association with the DoD. A coverage plan status of "eligible for" identifies the coverage and eligibility period a beneficiary is qualified to enroll into the coverage plan. A coverage plan status of "enrolled" identifies that a beneficiary has an enrollment into the coverage plan for the enrollment period. The Eligibility for Enrollment Inquiry will identify the assigned, enrolled, and eligible for coverage plans for a person. Each coverage plan will have a status and an associated eligibility or enrollment period.

For example, all coverage plans for TRICARE Standard and Direct Care have a status of "assigned" and will also have associated eligibility begin and end dates. For a person enrolled into a TRICARE Prime coverage plan, the first instance of the coverage plan would have a status of "enrolled" and the associated enrollment period. There would also be a second instance of the coverage plan with a status of "eligible for" and the associated eligibility period for the coverage plan. The second instance identifies the complete period of eligibility for a specific coverage plan whereas the first instance only identifies the period of the enrollment. The complete period of eligibility is used to ensure that changes to an enrollment are within the eligibility period for the coverage plan, such as changing an enrollment begin or end date.

The following illustrations show the information for an Eligibility for Enrollment Inquiry/Response for an active duty sponsor. Examples with and without an enrollment are provided.

Figure 10. Coverage Plan Status Without an Enrollment

Figure 11. Coverage Plan Status With an Enrollment

5.3.2.5 DEERS Reported Changes to Eligibility

There are multiple conditions that effect a person's eligibility for benefits on DEERS. When the end date is known at the time of enrollment, DEERS reports this to the enrolling organization in the Eligibility for Enrollment Inquiry Response. DEERS will not send notifications to report these known changes to the enrollment management organization(s). The definitive states are:

- Upon reaching age 65. DEERS maintains two primary rules for civilian health care eligibility related to Medicare eligibility: if under age 65, a beneficiary is not Medicare eligible; if age 65 and over, a beneficiary is Medicare eligible. Conditions that do not meet those rules are considered exceptions. Every beneficiary is considered entitled to Medicare Part A at age 65 until they report otherwise. DEERS returns the date the beneficiary attains age 65 in the Eligibility for Enrollment Inquiry Response. DEERS does not send an unsolicited notification that the beneficiary has reached age 65.

- Child upon reaching age 21. DEERS reports the end of eligibility as the day prior to the 21st birthday in the Eligibility for Enrollment Inquiry Inquiry Response. DEERS does not send an unsolicited notification that the beneficiary has reached age 21.

- Child upon reaching age 23. DEERS reports the end of eligibility as the day prior to the 23rd birthday in the Eligibility for Enrollment Inquiry Response. DEERS does not send an unsolicited notification that the beneficiary has reached age 23.

- Transitional Assistance Management Program (TAMP). DEERS reports the end of the TAMP period in the Eligibility for Enrollment Inquiry Response. DEERS does not send an unsolicited notification that the beneficiary has completed the TAMP period.

- Reservist or National Guard on active duty. DEERS reports the recorded end of the active duty period for Reservists on active duty as a definitive end date in the Eligibility for Enrollment Inquiry Response. DEERS does not send an unsolicited notification that the Reservist or National Guard member has completed the active duty period.

If there is a previously unknown change in the coverage of a service member or family member that impacts a current or future enrollment, DEERS will report the coverage change to the enrollment management organization(s) via an unsolicited notification. These reported changes may be the result of a loss in eligibility that is less than previously reported. When the family is enrolled in multiple locations, DEERS will notify all locations about those changes. Some examples include: a reported separation from active service, a separation into TAMP, a separation into retirement, the marriage of a child, a child joining the service, the death of the service member or a family member, or a reported change in the date of birth making the sponsor or family member age 65 sooner than previously shown.

DEERS will not notify the enrollment management organization about a change in eligibility that results in a longer eligibility. An example of this type of change is an enlisted sponsor's extending his or her enlistment, or reenlisting.

Another example is the case in which a sponsor dies while on active duty and the family members are eligible for continued coverage as TRICARE Standard for Survivors of Active Duty Deceased Sponsors or Tricare Prime for Survivors of Active Duty Deceased sponsors for one year after the death of the sponsor. After the one year period the family members are eligible to enroll into the retiree health care plans. If the family members do not enroll into a retiree health care plan, DEERS will assign the TRICARE Standard retiree plan.

5.3.3 Enrollment

When a sponsor and family member are first added into DEERS, DEERS will determine basic eligibility for health care benefits based on DoDI 1000.13 and establish an assigned HCDP Coverage Plan together with coverage dates.

For example, when an active duty sponsor and family members are added to DEERS:

- A sponsor will be given a Direct Care for Active Duty Sponsors policy in which he or she is the subscriber and the insured with direct care entitlement only. The dates on the coverage will represent the dates determined by the eligibility rules.
- A sponsor with family members will be listed as the subscriber under the TRICARE Standard for Active Duty Family Members policy. The sponsor is not insured under this coverage plan.
- Eligible family members will be given a TRICARE Standard for Active Duty Family Members policy as insured with both direct care and civilian health care coverage. The coverage dates will be determined by the eligibility rules. There will be no enrollment dates, since this option requires no enrollment.

Figure 12. TRICARE Standard: Sponsor and Family Member as Subscriber and Insured

5.3.3.1 Health Care Delivery Plans Requiring Enrollment

Certain HCDPs require the beneficiary to elect enrollment. Refer to Appendix F, Business Rules Matrix for specific enrollment rules for each health coverage plan. DEERS will support enrollment activities for the following health care coverage plans:

- TRICARE Prime:
  - TRICARE Prime Individual Coverage for Active Duty Sponsors
  - TRICARE Prime Individual Coverage for Active Duty Family Members
  - TRICARE Prime Family Coverage for Active Duty Family Members
  - TRICARE Prime for Survivors of Active Duty Deceased Sponsors
  - TRICARE Prime Individual Coverage for Retired Sponsors and Family Members
  - TRICARE Prime Family Coverage for Retired Sponsors and Family Members
  - TRICARE Prime Individual Coverage for Transitional Assistance Sponsors and Family Members
  - TRICARE Prime Family Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE Remote
  - TRICARE Remote for Active Duty Sponsors
  - TRICARE Remote Individual Coverage for Active Duty Family Members
  - TRICARE Remote Family Coverage for Active Duty Family Members
- TRICARE Senior Prime Individual Coverage for Retired Sponsors and Family Members
- USFHP
  - TRICARE USFHP Individual Coverage for Active Duty Family Members
  - TRICARE USFHP Family Coverage for Active Duty Family Members
  - TRICARE USFHP Individual Coverage for Retired Sponsors and Family Members
  - TRICARE USFHP Family Coverage for Retired Sponsors and Family Members
  - TRICARE USFHP Individual Coverage for Transitional Assistance Sponsors and Family Members
  - TRICARE USFHP Family Coverage for Transitional Assistance Sponsors and Family Members
- FEHBP
  - Federal Employees Health Benefits Program (FEHBP) Individual Standard Coverage
  - Federal Employees Health Benefits Program (FEHBP) Family Standard Coverage
  - Federal Employees Health Benefits Program (FEHBP) Individual High Coverage
  - Federal Employees Health Benefits Program (FEHBP) Family High Coverage
- CHCBP
  - Continued Health Care Benefit Program Individual Coverage

- Continued Health Care Benefit Program Family Coverage

5.3.3.2 TRICARE Prime Enrollment Example

Enrollments are performed by MCSCs, which are referred to as *enrolling organizations*. One example of a TRICARE Prime enrollment is that of an individual who is eligible for the basic benefit of civilian health care or direct care.

- Using the information provided in the Eligibility for Enrollment Inquiry Response, a sponsor showing a coverage plan of Direct Care for Active Duty Sponsors could be enrolled in TRICARE Prime Individual Coverage for Active Duty Sponsors. Enrollment data for the sponsor would be sent to DEERS as both a subscriber and as an insured.
- Using the information provided in the eligibility or coverage response, a family member showing a coverage plan of TRICARE Standard for Active Duty Family Members could be enrolled in TRICARE Prime Individual Coverage for Active Duty Family Members or TRICARE Prime Family Coverage for Active Duty Family Members. In this case, enrollment data sent to DEERS would identify the sponsor as a subscriber only, and the family members as the insureds.

The following diagram illustrates how the information under the sponsor and family members' records will be organized.

Figure 13. TRICARE Prime: Sponsor and Family Member as Subscriber and Insured

5.3.3.3 Information Sent for Enrollment

Enrollment is not required to participate in either TRICARE Standard or TRICARE Extra coverage plans.

The DEERS Id is required for any enrollment, re-enrollment, modification of enrollment, or disenrollment transaction. If the DEERS Id is unknown, an eligibility for enrollment inquiry must be performed to obtain it.

When enrolling an individual or family, the enrolling organization must send identifying information for the individual(s) to be enrolled:

- HCDP information, including the effective dates of the enrollment
- Enrollment fees, if applicable
- PCM information
- Medicare Health Insurance Claim Id for TRICARE Senior Prime

Enrollments may be established with effective dates that are current, up to 60 days in the past, or up to 90 days in the future.

The enrollment period cannot exceed one year or the end of eligibility. The only exception to this is the active duty service member whose enrollment is indefinite as long as eligibility is maintained. Both the DEERS "assigned" and "eligible for" coverage are used to determine the coverage plan into which the beneficiary may enroll. DEERS will validate that the enrolled coverage plan sent with an enrollment is valid, based upon the coverage plan status. Also, DEERS will not enforce enrollment lockouts and therefore will provide enrollment end reasons during eligibility inquiries. The enrolling organization can use this information to determine if the beneficiary is eligible for enrollment or to enforce the enrollment lockout. The enrolling organization is responsible for assigning a PCM if required by the coverage plan when the beneficiary has not selected one. The selected PCM must be in the same region as the organization managing the beneficiary's enrollment.

If a beneficiary wishes to enroll or re-enroll into a program, the enrolling organization must check for eligibility using the Eligibility for Enrollment Inquiry with the projected enrollment effective date. DEERS allows a beneficiary to enroll up to 60 days in the past or 90 days in the future. If the response identifies the beneficiary is currently eligible, but the eligibility is expected to terminate within the new enrollment year, the beneficiary is still able to enroll into the desired health plan for the period of eligibility. A limited period of future eligibility should not prevent a beneficiary from enrolling in a coverage plan.

Enrollment fees are required for the following coverage plans:

- TRICARE Prime Individual Coverage for Retired Sponsors and Family Members
- TRICARE Prime Family Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Individual Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Family Coverage for Retired Sponsors and Family Members
- Continued Health Care Benefit Plan (CHCBP) Individual Coverage
- Continued Health Care Benefit Plan (CHCBP) Family Coverage

Enrollment fees may be paid monthly, quarterly or annually. The beneficiary specifies this payment option during enrollment as well as if the fees are for an individual or family policy. DEERS will record the date an enrollment fee payment was made and the date through which coverage is paid as the information is sent to DEERS. The enrollment fee paid-through date reflects the time period for which coverage is paid. For example, a quarterly fee payment received for coverage between January 1 through March 31 would reflect a March 31 enrollment fee paid-through date. The date does not represent when the enrollment fee payment information was received or sent to DEERS. The purpose of tracking what period an enrollment fee covers is important for portability. If a person transfers their enrollment from Region 1 to Region 5 and has paid for coverage through March 31, Region 5 could use this information to determine that an enrollment fee payment is not due until April 1.

In the Eligibility for Enrollment Inquiry, the catastrophic cap totals may be returned in the response to help determine if enrollment fees should be collected. The catastrophic cap

totals will only be included when the assigned coverage plan allows an enrollment into a coverage plan that requires enrollment fees. However, DEERS does not lock catastrophic cap and deductible accumulations in an eligibility inquiry. If enrollment fees are applicable for an enrollment, the enrolling organization should determine the order of events for sending the enrollment to DEERS, inquiring and locking the catastrophic cap and deductible totals, and updating the catastrophic cap amounts with the enrollment fee payment information. DEERS will not automatically apply enrollment fees to catastrophic cap accumulations; this is the responsibility of the organization managing the enrollment fees.

Under certain circumstances, enrollment fees may not be required because the catastrophic cap amount has been met or a fee payment is waived for an individual. If the catastrophic cap amount has been met for the family, either partial enrollment fees or no fee payments may be collected for that period. This non-payment or partial enrollment fee payment will be sent to DEERS indicating the catastrophic cap was met for this period. It is necessary for DEERS to have this information for portability. Enrollment fee waivers are associated at the individual beneficiary level and should be sent to DEERS. The waiver information includes the reason for the enrollment fee waiver. DEERS will not track dates associated with the enrollment fee waiver. The fee payment waiver status for an individual is used to distinguish between enrollment fees that were waived versus those that were not paid.

If additional beneficiaries are added to an existing family enrollment, and enrollment fees are current for the policy, no accompanying fee payment information is necessary. Additionally, when an individual moves between regions, the new enrolling organization will be able to query DEERS to see if the enrollment fees are current for the policy. Enrollment fees are accumulated at the subscriber level for the policy. Therefore, in a family policy, if enrollment fees are current, the individual family member who is located separately from the family will not pay another separate enrollment fee.

The PCM information that must be sent with all coverage plans requiring an enrollment includes the region, network affiliation, and enrolling division DMIS Id. Depending on the network affiliation, additional PCM information may also be supplied at the time of the enrollment. Refer to the rules associated with an enrollment in Appendix F, Business Rules Matrix.

For enrollment into the TRICARE Senior Prime program, enrolling organizations must send the Medicare Health Insurance Claim Id in the enrollment transaction. This identifier may be used to communicate information about the beneficiary to the Health Care Financing Administration (HCFA).

The following general updates can accompany an enrollment transaction:

- Address and/or telephone number
- OHI

For more information on these events, see the General Updates, and Other Health Insurance sections of this document.

Under certain circumstances, it may be necessary to cancel an enrollment. DEERS will accept enrollment cancellations by changing the enrollment period with the appropriate

reason for ending the enrollment. Refer to the Enrollment Cancellation section for detailed information necessary for canceling an enrollment.

5.3.3.4 Enrollment Into Individual and Family Coverage Plans

An *individual coverage plan* provides benefits to one individual. DEERS will ensure that multiple instances of the same individual coverage plan do not exist under one subscriber. A *family coverage plan* provides benefits to one or more individuals. It is possible for one individual to enroll into a family coverage plan. All enrollment begin and end dates of individuals enrolled into a family coverage plan must fall within the same 12-month period beginning with the enrollment anniversary date. This period is called the *policy enrollment period.*

When changing among individual and family coverage plans, a new enrollment period always begins, and any catastrophic cap and deductible accumulations remain with the policy and enrollment period for which they accumulated; the amounts do not carry over to the new coverage plan. It is not necessary to switch to an individual coverage plan when a family coverage plan exists and all family members have disenrolled except for one individual. If desired, the individual family member can choose to switch to an individual coverage plan. However, it is necessary to switch from individual to family coverage plans when more than one individual is enrolled into a policy.

To enroll multiple family members when an individual coverage plan already exists, the enrolling organization must terminate the individual coverage plan and a new family coverage plan should be added to DEERS. A new policy enrollment period would begin for the family coverage plan, with a new enrollment anniversary date. All catastrophic cap and deductible accumulations would remain for the individual coverage plan; these amounts would not carry over to the family coverage plan.

In the case of a split enrollment that switches from individual to family coverage plans, the region initiating the enrollment into the family coverage plan would notify DEERS of the enrollment. DEERS would disenroll the family member from the individual coverage plan, with an end date one day prior to the family plan enrollment begin date, and enroll him or her into the family coverage plan, extending the enrollment end date to the full 12-month period, assuming eligibility. DEERS would notify the other region of the enrollment change from an individual coverage to a family coverage plan for the family member.

> For example, if an individual is enrolled in an individual coverage plan in Region 1 from 1/1/99 – 12/31/99 and another family members enrolls in Region 3 on 4/1/99, the following events would occur.
>
> - Region 3 would send a new family coverage plan enrollment for the second family member in Region 3 effective for 4/1/99 – 3/31/00.
> - DEERS would disenroll the individual in Region 1 from the individual coverage plan effective 3/31/99 and enroll him or her into the family coverage plan, effective 4/1/99 – 3/31/00.

- DEERS would send Region 1 an enrollment notification indicating that a policy change occurred from individual to family coverage. Region 1 should notify the beneficiary of the change in coverage plans from individual to family.

5.3.3.5 Retroactive Enrollments

Enrollments can be done with begin dates up to 60 days in the past. For example, if an enrollment were received 3/1/1999, the enrollment begin date could not be prior to 1/1/1999. For retroactive enrollments needing begin dates more than 60 days in the past, requests should be performed by the TRICARE Management Activity-Aurora (TMA). DEERS will not accept retroactive enrollments effective more than 60 days in the past from organizations other than TMA. Currently, an exception to the 60-day time period for retroactive enrollments is the enrollment of a newborn. A retroactive enrollment can be done for a newborn effective back to the date of birth within the first year of birth.

5.3.3.6 Enrollment Anniversary Date

The enrollment anniversary represents the effective date of a policy enrollment period. For enrollments into individual coverage plans, the anniversary date is the begin date of that person's enrollment. For a family coverage plan, the date is the begin date of the first person to enroll into that coverage plan.

> For example, an enrollment into TRICARE Prime Individual Coverage for Retired Sponsors and Family Members effective 1/1/1999 through 12/31/1999 would have an enrollment anniversary date of 1/1/1999. For a three-person family in TRICARE Prime Family Coverage for Retired Sponsors and Family, two family members have an enrollment period in this policy of 1/1/1999 through 12/31/1999 and another family member has an enrollment period in this policy of 4/1/1999 through 12/31/1999. The enrollment anniversary date is 1/1/1999 for the policy and all family members share this date. Each individual in a family coverage plan may have a different enrollment begin date. However, the individual enrollment begin date cannot be prior to the policy enrollment anniversary date. All family members should have the same enrollment end date, assuming eligibility.

DEERS sets the enrollment anniversary date for a policy during the initial enrollment into a coverage plan. DEERS updates the enrollment anniversary date when there is a re-enrollment into a coverage plan. The enrollment anniversary date may also be updated when there is a change in the enrollment period. DEERS will only allow the enrollment management systems to effect those changes in the enrollment period that affect the enrollment anniversary date under certain circumstances. DEERS does not push changes to the enrollment anniversary date to entities managing enrollments because DEERS pushes the enrollment period changes to these organizations. The enrollment anniversary date is returned with an Eligibility for Enrollment Inquiry or a coverage inquiry response.

5.3.3.7 Enrollment Notifications

There may be several enrolling organizations for a policy and it is necessary for DEERS to communicate enrollments to them. Enrollments may be performed by an organization that

is managing the enrollment while another entity is responsible for providing care to the beneficiary, such as an enrollment to a Direct Care PCM. To alleviate inconsistencies and ensure that all parties are informed of the enrollments in which they participate, DEERS will send enrollment notifications under the following circumstances:

- For enrollments performed by the MCSC that have Direct Care PCM selections, DEERS will push the enrollment information to the MTF associated with the PCM Enrolling Division DMIS Id.
- For enrollments performed by the MCSC that have civilian PCM selections, DEERS will *not* push the enrollment information to the MTF associated with the PCM Enrolling Division DMIS Id.

The enrollment notifications will be pushed for new enrollments, re-enrollments, modifications of enrollments, and disenrollments as necessary, based on the information stated above.

- For enrollment notifications sent to the MCSC, the DEERS Id will be used to identify the beneficiary.
- For enrollment notifications sent to the MTF, the Patient Id will be used to identify the beneficiary.

The first diagram below illustrates the data passed to DEERS to perform an enrollment for an individual. The second diagram details an enrollment notification transaction.

Figure 14. Enrollment Into Health Benefit Program

Figure 15. Enrollment Notification from DEERS

5.3.4 Addition and Enrollment of a Newborn Beneficiary Into DEERS

DEERS will allow enrolling organizations and clinical sites to add newborn beneficiaries not yet registered with a verifying official. To add a newborn to DEERS, it is necessary to identify the correct family by sending an eligibility inquiry using the sponsor's identification data. DEERS will respond to enrolling organizations with the sponsor's DEERS Id, which the enrolling organization must use to add the newborn into DEERS as a beneficiary. DEERS will respond to clinical sites with the sponsor's Patient Id, which must be used to add the newborn into DEERS as a beneficiary.

The subsequent add transaction, from enrolling organizations and clinical sites, must also include the name, date of birth, and relationship to the sponsor. For requests sent by clinical sites, DEERS will use the Patient Id to locate the appropriate family, by identifying the associated DEERS Id that represents a sponsor. If there is no associated DEERS Id representing a sponsor, DEERS will reject the transaction. If the transaction is accepted, regardless of the source, DEERS will assign the newborn a DEERS Id, a Patient Id, a Temporary Id, and establish an assigned HCDP coverage plan with a maximum 365-day eligibility period from the date of birth and a Prime copayment factor for a maximum 120-day period from the date of birth.

After the newborn is added to DEERS and assigned a coverage plan, the enrolling organization can inquire as to the newborn's eligibility and assigned coverage plan. If desired, the enrolling organization can use this information to enroll the newborn into the appropriate coverage plan. The DEERS "assigned" and "eligible for" coverage status is used to determine the coverage plan into which to enroll the newborn. The enrollment period for the newborn cannot exceed the period of eligibility.

When DEERS receives notification from the verifying official validating the newborn's identity, DEERS will update the newborn beneficiary's eligibility period and, if necessary, send notifications to those systems managing the newborn's enrollment. After the notification is received, the enrollment management systems can update the enrollment end date accordingly and communicate the information to DEERS.

If the newborn is added to DEERS by a verifying official, DEERS will assign coverage through the end of their eligibility and a Prime copayment factor for 120 days from the date of birth. If desired, the newborn can be enrolled into the appropriate health coverage plan by an enrolling organization.

The length of eligibility for a newborn can be used to determine the source of this person's entry into DEERS. If the newborn only has a 365-day eligibility, it can be assumed MHS personnel added the newborn to DEERS. If the newborn has an eligibility period greater than 365 days, it can be assumed that a verifying official added the newborn to DEERS.

Newborns may be enrolled into these specific health care plans:

- TRICARE Prime Individual Coverage for Active Duty Family Members
- TRICARE Prime Family Coverage for Active Duty Family Members
- TRICARE Prime for Survivors of Active Duty Deceased Sponsors

- TRICARE Prime Individual Coverage for Retired Sponsors and Family Members
- TRICARE Prime Family Coverage for Retired Sponsors and Family Members
- TRICARE Prime Individual Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE Prime Family Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE Remote Individual Coverage for Active Duty Family Members
- TRICARE Remote Family Coverage for Active Duty Family Members
- TRICARE USFHP Individual Coverage for Active Duty Family Members
- TRICARE USFHP Family Coverage for Active Duty Family Members
- TRICARE USFHP Individual Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Family Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Individual Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE USFHP Family Coverage for Transitional Assistance Sponsors and Family Members

The following diagrams illustrate the data processes for newborn beneficiaries.

Figure 16. Addition of a Newborn Beneficiary to DEERS from Enrolling Organization

Figure 17. Addition of a Newborn Beneficiary to DEERS from MTF

1. Identify the family.
2. Add newborn beneficiary to DEERS using sponsor's DEERS Id or Patient Id, depending on the entity adding the newborn beneficiary. DEERS assigns coverage to newborn beneficiary and returns newborn DEERS Id or Patient Id and Temporary Id only.
3. Query DEERS for eligibility to obtain assigned coverage for newborn beneficiary.
4. Enroll newborn beneficiary into appropriate plan.

Figure 18. Process for Enrollment of a Newborn Beneficiary

5.3.5 Re-Enrollment

The following coverage plans require re-enrollment:

- TRICARE Prime Individual Coverage for Active Duty Family Members
- TRICARE Prime Family Coverage for Active Duty Family Members
- Remote Individual Coverage for Active Duty Family Members
- TRICARE Remote Family Coverage for Active Duty Family Members
- TRICARE Prime Individual Coverage for Retired Sponsors and Family Members
- TRICARE Prime Family Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Individual Coverage for Active Duty Family Members
- TRICARE USFHP Family Coverage for Active Duty Family Members
- TRICARE USFHP Individual Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Family Coverage for Retired Sponsors and Family Members

Enrolling organizations must perform annual re-enrollment for individuals enrolled in a coverage plan that requires an enrollment. The enrolling organization must send a re-enrollment request to DEERS, using the DEERS Id, within a prescribed period, which begins on the date the current enrollment expires. This period is currently 30 days. If DEERS does not receive a re-enrollment request within the prescribed period, DEERS will reflect the coverage plan for the beneficiary as the assigned coverage plan. If no re-enrollment transaction is received, DEERS does not send any system notifications that the enrollment expired. The enrolling organization should send DEERS a disenrollment notification if the beneficiary does not wish to extend their enrollment.

When DEERS receives the re-enrollment request, DEERS will re-enroll the individual for the next enrollment year, in accordance with the enrollment begin and end dates sent by the enrolling organization, carrying forward the individual's current selection for PCM if applicable. DEERS will validate that the re-enrollment begin and end dates are contiguous with the previous enrollment period to ensure that there are no gaps between the enrollments. DEERS will also change the enrollment anniversary date to reflect the new enrollment period.

Enrollment into TRICARE Prime and TRICARE Remote is indefinite for active duty sponsors, as long as their eligibility is maintained. DEERS supports continuous enrollment for active duty sponsors with an indefinite enrollment end date not to exceed the end of eligibility. DEERS supports continuous enrollments for family members through re-enrollment transactions sent by enrolling organizations. DEERS does not perform automatic enrollment or re-enrollment transactions. Currently, indefinite enrollment end

dates are only applicable for the following coverage plans:

- TRICARE Prime Individual Coverage for Active Duty Sponsors
- TRICARE Remote for Active Duty Sponsors

Re-enrollment activity does not apply for the following coverage plans:

- TRICARE Prime Individual Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE Prime Family Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE Senior Prime Individual Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Individual Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE USFHP Family Coverage for Transitional Assistance Sponsors and Family Members
- Continued Health Care Benefit Plan (CHCBP) for Individual Coverage
- Continued Health Care Benefit Plan (CHCBP) for Family Coverage

The following diagram details a re-enrollment for health benefits.

Figure 19. Re-Enrollment Into Health Benefit Program

5.3.6 Disenrollment

Once actively enrolled in a coverage plan, an individual or family may voluntarily disenroll or be involuntarily disenrolled. Voluntary disenrollment is self-elected. Involuntary disenrollment occurs from failure to pay enrollment fees, from loss of eligibility, or from removal by a verifying official. Disenrollment is restricted to the current enrollment period.

Multiple systems may be responsible for managing an enrollment. Potentially, there are three systems for an enrollment: 1) HCDP Enrollment Fee System; 2) HCDP Enrollment Management System; and 3) PCM Enrolling Division System. A disenrollment from a coverage plan will affect one or more of these systems and DEERS will notify them as necessary. DEERS will not send disenrollment notifications to all HCDP Enrollment Fee Systems associated with a policy. DEERS will only send a disenrollment notification to the last HCDP Enrollment Fee System communicating enrollment fee payment information.

Under certain circumstances, it may be necessary to cancel a disenrollment. DEERS will accept disenrollment cancellations only for the last enrollment, and only within 60 days of the disenrollment. A disenrollment is cancelled by changing the disenrollment period with

the appropriate reason for not terminating the enrollment. Refer to the Disnrollment Cancellation event for detailed information necessary for canceling a disenrollment.

5.3.6.1 Disenrollment — Loss of Eligibility

A loss of eligibility includes both a loss or change in eligibility for: 1) DoD health care benefits according to the current DoDI 1000.13; or 2) an individual health coverage plan. Under these circumstances, DEERS will terminate any current enrollment or cancel an enrollment effective at a future date.

DEERS will send an unsolicited disenrollment notification when loss of eligibility occurs. DEERS will not send a disenrollment notification for beneficiaries enrolled in any TRICARE USFHP or CHCBP health coverage plan, because these programs are not implemented through an EDI solution.

Because DEERS reapplies its rules-based logic each time benefits determination data about a sponsor or family member changes, certain events may trigger disenrollment.

For example, when the sponsor's eligibility terminates, such as upon separation from service, this will terminate coverage for the entire family, resulting in a disenrollment by DEERS. The termination of coverage will effect the insured's enrollment information, which will, in turn, terminate their current and/or cancel a future enrollment into an HCDP. An unsolicited disenrollment transaction will be sent to the necessary systems notifying them of the termination of coverage benefits.

The following diagram details a disenrollment of health benefits program due to loss of eligibility.

Figure 20. Disenrollment From Health Benefit Program — Loss of Eligibility

5.3.6.2 Disenrollment — Voluntary

An insured may choose to terminate his or her current enrollment prior to the end date, or choose not to re-enroll into the current coverage plan. This transaction will be sent from the enrolling organization to DEERS. DEERS will, in turn, terminate the coverage plan for the insured and revert to the DEERS-assigned coverage, starting on the day after the termination of the previous enrollment. If additional systems need notification of the disenrollment, DEERS will send disenrollment notifications as necessary via EDI notifying them of the termination of coverage benefits.

5.3.6.3 Disenrollment — Involuntary

The subscriber may fail to pay enrollment fees. In this case, the enrolling organization sends DEERS a disenrollment notification with a reason code of "failure to pay." This reason for disenrollment will cause a disenrollment for each beneficiary enrolled in this coverage plan. The only exception is the individual who is waived from paying enrollment fees. DEERS would not disenroll this person because of their exemption from enrollment fee payments.

Under this type of disenrollment, a lockout period applies before the subscriber can re-enroll. DEERS will send disenrollment notifications as necessary via EDI notifying the necessary systems of the termination of coverage benefits. The lockout period is currently

effective for 12 months following the disenrollment date. DEERS will not enforce enrollment lockouts. DEERS will provide enrollment end reasons during eligibility inquiries. The enrolling organization can use this information to determine if the beneficiary is eligible for enrollment or to enforce the enrollment lockout. For more information, refer to the Eligibility for Enrollment section and Appendix F, Business Rules Matrix.

Involuntary disenrollment may also occur due to improper conduct or other extraordinary circumstances. This may result in either individual or family disenrollments; DEERS, however, will only automatically disenroll all family members in a policy for failure to pay fees (with the exception of individuals with fee wavers) or at the request of a sponsor to disenroll all family members. All other disenrollments must be performed for each insured.

5.3.6.4 Disenrollment Affecting Split Enrollments

As mentioned previously, split enrollments occur when all family members are covered under the same policy and do not reside in the same geographic location, causing the policy to be administered by multiple regions. When a voluntary disenrollment takes place for only one individual under a policy, no additional notifications will be made, regardless of whether or not that individual was considered by the enrolling organization to be the enrollment fee payer. However, if an involuntary disenrollment takes place for all family members under a policy for failure to pay enrollment fees, additional disenrollments and notifications may be necessary. In this situation, all family members except those waived from enrollment fee payments will be disenrolled, with an enrollment reason indicating failure to pay enrollment fees. Additionally, if an enrolling organization sends DEERS a disenrollment for an individual in a policy with an enrollment end reason indicating the sponsor's desire to terminate the policy, DEERS will disenroll all family members enrolled in the policy, and send disenrollment notifications accordingly.

> For example, a sponsor and two children live in Region 3 and two other children live in Region 5; all children are covered under the same policy. If Region 3 sends a disenrollment notification to DEERS for failure to pay enrollment fees, Region 3 cannot disenroll the children in Region 5. DEERS would disenroll children in Region 5 and send a disenrollment notification to that enrolling organization. If any one of the individuals in either region was waived from fee payments, that beneficiary could not be disenrolled due to failure to pay enrollment fees.

The following diagram details disenrollment, whether voluntary or involuntary.

Figure 21. Disenrollment From Health Benefit Program — Voluntary or Involuntary

5.3.7 Modification of Current Enrollment

There are several reasons to modify a current enrollment:

- Change or cancel a PCM selection
- Transfer enrollment (enrollment portability)
- Change enrollment begin or end date
- Change enrollment end reason
- Cancel enrollment/disenrollment

When there is a modification to a current enrollment, the appropriate systems will be notified, as necessary, if there are changes in the systems managing the enrollment. Potentially, there are three systems for an enrollment: 1) HCDP Enrollment Fee System; 2) HCDP Enrollment Management System; and 3) PCM Enrolling Division System. Refer to the Enrollment Notifications section for additional information.

5.3.7.1 PCM Change and Cancellation

A person currently enrolled in TRICARE Prime or TRICARE USFHP coverage plans may desire to change PCMs, although he or she is not relocating. Only the current system responsible for managing the person's enrollment may change the PCM selection. A PCM change can occur at any time during an active or future enrollment, including the re-enrollment grace period. A PCM change does not constitute a re-enrollment. A PCM change is done for one enrollment. If a beneficiary wishes to change his or her PCM selection for both current and future enrollment periods, two separate PCM change notifications must be sent to DEERS. The DEERS Id is required to change PCMs. A PCM change may include a change in the network provider type; however, the PCM region cannot be updated in this transaction. The selected PCM must be in the same region as the organization managing the beneficiary's enrollment. To update the PCM region, a transfer of enrollment event should be performed.

DEERS will terminate the previous PCM with an end date, which will be the day before the begin date for the new PCM. For example, if the new PCM begins on 5/1/99, the system will automatically place an end date of 4/30/99 on the previous PCM.

When canceling a PCM change, an eligibility inquiry should be done to ensure that the changes are performed on the most current enrollment information. The PCM cancellation can only be done to the most current policy in effect or to a future enrollment into a different coverage plan. Cancellation of a PCM change can only be performed by the organization managing the enrollment. There can be no gaps within PCM selections for an enrollment that requires a PCM; when DEERS receives a PCM change cancellation, DEERS will extend the end date of the previous PCM selection to the end of the enrollment period. If there is no previous PCM selection, DEERS will not accept the PCM change cancellation, unless a new PCM selection accompanies the cancellation. The information required to cancel a PCM change is similar to that of a PCM change with a PCM Selection End Reason value of "invalid entry." DEERS will notify the necessary systems of the PCM change cancellation.

The specific information needed to change a PCM and cancel PCM changes is listed in the following diagrams.

Figure 22. Modification of Health Benefit Program Enrollment (PCM Change)

The following is a sample illustration of the cancellation of a PCM Change.

Figure 23. Cancel PCM Change Example

The following diagram details a PCM cancellation.

Figure 24. Modification of Health Benefit Program Enrollment (PCM Cancellation)

5.3.7.2 Transfer of Enrollment (Enrollment Portability)

Transfer of enrollment applies to TRICARE Prime and TRICARE USFHP coverage plans. The following coverage plans allow enrollment transfers:

- TRICARE Prime Individual Coverage for Active Duty Sponsors
- TRICARE Prime Individual Coverage for Active Duty Family Members
- TRICARE Prime Family Coverage for Active Duty Family Members
- TRICARE Prime for Survivors of Active Duty Deceased Sponsors
- TRICARE Prime Individual Coverage for Retired Sponsors and Family Members
- TRICARE Prime Family Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Individual Coverage for Active Duty Family Members
- TRICARE USFHP Family Coverage for Active Duty Family Members
- TRICARE USFHP Individual Coverage for Retired Sponsors and Family Members

- TRICARE USFHP Family Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Individual Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE USFHP Family Coverage for Transitional Assistance Sponsors and Family Members

If a subscriber or insured sponsor or family member currently enrolled in TRICARE Prime or TRICARE USFHP relocates to another region and remains in the same health benefit program, the insured does not need to disenroll. The beneficiary should go to the new region's enrolling organization to perform a transfer of enrollment. One example of this would be the case in which one family member goes off to college in another state and the rest of the family remains in their original location.

The enrollment items changing under this scenario are PCM region and PCM Enrolling Division information. The enrollee will need to contact the new enrolling organization in order to obtain a new PCM for the new region. If there was a change in any one of the systems, as a result of a region, network provider type, or PCM change for TRICARE Prime enrollees, DEERS will accordingly notify the affected systems, via EDI, that the insured has terminated coverage with their organization. This notification will be similar to a disenrollment notification. HCDP Enrollment Management Systems cannot update policies that are not managed by their respective region. DEERS is the intermediary and communicates enrollment changes between regions. If the transfer of enrollment does not result in a change of these systems, no disenrollment information will be sent to the losing organization from DEERS.

In addition, if a beneficiary changes his or her PCM selection and the new PCM is in another region, this is an enrollment transfer, not a PCM change. This situation is also considered an enrollment transfer because the enrollment is associated with a different region through the PCM selection.

DEERS supports portability among coverage plans within a health benefit program (e.g. coverage plans within TRICARE Prime). Portability does not exist between health benefit programs (e.g., TRICARE Prime and TRICARE USFHP). If a beneficiary is enrolled in TRICARE Prime and wishes to enroll into TRICARE USFHP or vice versa, a transfer of enrollment is not applicable, a disenrollment from TRICARE Prime and a new enrollment into TRICARE USFHP must be established.

The rules associated with the enrollment transfers can be found in Appendix F, Business Rules Matrix. DEERS will ensure that the information necessary to perform the transfer is provided to the enrolling organization.

Note: When DEERS receives an enrollment transfer, DEERS will terminate the old PCM selection. The end date for the old PCM selection will be the day before the begin date for the new PCM selection. The beneficiary is not required to disenroll from the old enrollment organization. DEERS will accordingly notify the systems previously responsible for maintaining the policy.

Canceling an enrollment transfer is similar to canceling a PCM. In this scenario, however, DEERS would notify the previous region of the reinstatement of the PCM selection. Refer to the Cancel a PCM section for detailed information.

The following diagram shows the data elements within a transfer of health benefit program enrollment.

Figure 25. Modification of Health Benefit Program Enrollment (Transfer)

The following is a sample illustration of the cancellation of an enrollment transfer.

Figure 26. Cancel Transfer Enrollment Example

5.3.7.3 Enrollment Period Change for an Individual

This event is used to update an individual's enrollment. It is not intended to update all family member enrollments within a policy. The ability to update a current enrollment period can include changing both the enrollment begin and end dates. Enrollment period changes can only be done by the entity managing the enrollment. The enrollment period can only be changed for the policy currently in effect, or changed to a future enrollment. If there is a future re-enrollment into the same coverage plan as the current, DEERS will only allow an update to the enrollment period for the future enrollment. The following examples provide further explanation:

> *Example 1*: Enrollment followed by re-enrollment into the same coverage plan: There is a current enrollment into TRICARE Prime Family Coverage for Active Duty Family Members effective 1/1/1999 through 12/31/1999 and a future re-enrollment into the same coverage plan effective 1/1/2000 through 12/31/2000. If an enrollment period change is sent to DEERS, DEERS will only allow an update to the future enrollment period. In this example, the future enrollment period is 1/1/2000 through 12/31/2000.
>
> *Example 2*: Enrollment followed by an enrollment into a different coverage plan: There is a current enrollment into TRICARE Prime Family Coverage for Active Duty Family Members effective 1/1/1999 through 12/31/1999. There is also a new enrollment into TRICARE Prime Family Coverage for Retired Sponsors and Family Members plan for the future period effective 1/1/2000 through 12/31/2000. If an enrollment period change is sent to DEERS, DEERS will allow enrollment period updates to both coverage plans because the coverage plans are different.

When changing the enrollment period, the dates must not exceed 12 months or the end of eligibility, whichever comes first. As previously mentioned, the only exception to this is the active duty service member whose enrollment is indefinite as long as eligibility is maintained. DEERS will change the date range for PCM selections based on enrollment period changes.

The enrollment begin date can only be changed for the initial enrollment period into a coverage plan when that initial enrollment period has not yet expired. In addition, the change can only be performed by the entity responsible for creating the enrollment. If a re-enrollment exists for a coverage plan, the enrollment begin date cannot be updated.

When changing the enrollment begin or end date for an individual in an *individual* coverage plan, DEERS will also change the enrollment anniversary date to reflect the new enrollment period. When changing the enrollment begin or end date for an individual in a *family* coverage plan, the dates must remain within the family policy enrollment period.

If an enrollment fee payment for the policy was previously sent to DEERS, the enrolling organization may update the paid-through date, as necessary, using the Enrollment Fee Payment transaction.

If a person's eligibility in DEERS changes and affects an enrollment because the eligibility period is less than originally stated, DEERS will update the enrollment period and push the enrollment changes to the appropriate systems managing the enrollment.

> For example, a sponsor was originally retiring on April 1. The sponsor was eligible and enrolled into TRICARE Prime Family Coverage for Retired Sponsors and Family Members effective 4/1/1998 through 3/31/1999. If DEERS later receives information that the retirement date changed to May 1, DEERS would change the enrollment period for this coverage plan to 5/1/1998 through 4/30/1999. DEERS would update the enrollment end date for this coverage plan for the original 12-month period selected by the beneficiary. DEERS would also notify all systems managing the enrollment of the change to the enrollment period. If the retirement date changes to March 1 and an enrollment exists for Prime for Active Duty, DEERS would update the enrollment as necessary to ensure that no loss of coverage occurs and the dates remain within the original enrollment period selected by the beneficiary. DEERS would send the enrollment change notifications to all systems managing those enrollments.

The following diagram displays the data elements required to change to an individual's enrollment period.

Figure 27. Enrollment Period Change for an Individual

5.3.7.4 Enrollment Period Change for a Family

This event is used to update the enrollment period for all family members within a policy. This event will ensure that all family members within a policy remain within the same 12-month policy enrollment period. The ability to update a family enrollment period may include changing both the enrollment begin and end dates. Enrollment period changes can only be done by the entity managing the enrollment for a policy currently in effect or to a future enrollment.

This event differs from the change to an individual enrollment period because one notification to DEERS will result in the update of all enrollments for that policy. This transaction would be sent indicating a change to the "family" enrollment period. The subscriber information must be sent for this event. DEERS will update each individual enrollment begin and end date to be in sync with the new family begin and end date period as necessary, assuming eligibility. If the current individual enrollment begin date is different from the current anniversary date, DEERS will honor this difference when it performs the changes to family enrollment period.

> For example, there is a current anniversary date period of 1/1/99 through 12/31/99 and three individuals are enrolled in the policy, each having different enrollment begin and end dates (due to differing termination of eligibility) within this period.

The enrollment period for Person 1 is 1/1/99 through 12/31/99, Person 2 is 1/1/99 through 6/30/99, and Person 3 is 6/1/99 through 12/31/99. The family enrollment period is being changed to 11/1/98 through 10/31/99. DEERS would honor the different enrollment begin and end dates and adjust the enrollments as follows: Person 1 is 11/1/98 through 10/31/99, Person 2 is 11/1/98 through 6/30/99, and Person 3 is 6/1/99 through 10/31/99.

If there is a future re-enrollment into the same coverage plan as the current, DEERS will only allow an update to the enrollment period for the future enrollment. If there is a current enrollment into one coverage plan and a future enrollment into a different coverage plan and an enrollment period change is sent to DEERS, DEERS will allow enrollment period updates to both coverage plans because the coverage plans are different. When changing the enrollment period, the dates must not exceed 12 months or the end of eligibility, whichever comes first. As previously mentioned, the only exception to this limitation is the active duty service member whose enrollment is indefinite as long as eligibility is maintained. DEERS will change the date range for PCM selections based on enrollment period changes.

The enrollment begin date can only be changed for the initial enrollment period into a coverage plan when that initial enrollment period has not yet expired, and the change can only be performed by the entity responsible for creating the enrollment. If a re-enrollment exists for a coverage plan, the enrollment begin date cannot be updated. Changes to the enrollment begin date also effect the anniversary date and are therefore restricted to the initial enrollment into the coverage plan. DEERS will also change the enrollment anniversary date to reflect the new enrollment period.

If an enrollment fee payment for the policy was previously sent to DEERS, the enrolling organization may update the paid-through date, as necessary, using the enrollment fee payment transaction.

In the split enrollment situation, DEERS would update the enrollment period for the beneficiaries in the other region(s) and notify the appropriate systems managing the enrollment.

The following figure displays the data elements required to change to a family's enrollment period.

Figure 28. Enrollment Period Change for a Family

5.3.7.5 Enrollment End Reason Change

Disenrollments can be done for several reasons, some of which are performed by enrolling organizations. If a disenrollment is done by an enrolling organization with an incorrect end reason code, the enrollment end reason can be updated and the information sent to DEERS. This does not cancel the disenrollment. The enrollment end reason change will be reflected and DEERS will not transmit this change of enrollment information. If necessary, in split enrollment situations, DEERS will send enrollment notifications. For example, if the original enrollment end reason was "involuntary" and the correct reason was "dissatisfied with program," this change could be made in DEERS.

The following diagram displays the data elements within a change to an enrollment end reason.

Figure 29. Enrollment End Reason Code Change

5.3.7.6 Enrollment Cancellation

Cancellations cannot be performed on DEERS assigned coverage plans. Canceling an enrollment can only be done by the entity managing the enrollment. The enrollment can only be cancelled for the policy currently in effect or to allow a future enrollment. DEERS will only allow cancellations of the current policy within the first 60 days of the enrollment begin date. If there is a future re-enrollment into the same coverage plan, DEERS will allow the cancellation of the future enrollment.

Enrollment Cancellations cannot be performed for policies that are locked due to updates of catastrophic cap and deductible data. The enrollment can be cancelled once the lock is removed or expires. In addition, adjustments to enrollment fees or catastrophic cap and deductible accumulations should be done prior to the cancellation of the enrollment. DEERS will not delete enrollment fee payments or catastrophic cap and deductible accumulations for the enrollment year if the enrollment is cancelled. These payments and accumulations will remain intact. If a new enrollment was sent to DEERS for that time period, these payments and accumulations would be shown. If no enrollment was received, these payments and accumulations would not be shown for that enrollment year period because there was no associated enrollment.

For example, there is a current enrollment into TRICARE Prime Family Coverage for Active Duty Family Members effective 1/1/1999 through 12/31/1999 and a re-enrollment into the same coverage plan effective 1/1/2000 through 12/31/2000. If an enrollment cancellation is sent to DEERS, DEERS will only allow a cancellation of the last enrollment period, in this example the enrollment period 1/1/2000 through 12/31/2000.

In another example, there is a current enrollment into TRICARE Prime Family Coverage for Active Duty Family Members effective 1/1/1999 through 12/31/1999 and a new enrollment into TRICARE Prime Family Coverage for Retired Sponsors and Family Members plan effective 1/1/2000 through 12/31/2000. DEERS will allow enrollment cancellations to both coverage plans because the coverage plans are different. Upon receiving an enrollment cancellation, DEERS will reflect the DEERS assigned coverage plan for the cancelled enrollment period. DEERS will notify the appropriate systems of the enrollment cancellation.

In the split enrollment situation, DEERS would not cancel the enrollments or send notifications for the beneficiaries in the other region(s). Enrollment cancellations are done individually and a region cannot cancel enrollments, or portions of enrollments, that are not managed by their region.

The information necessary to cancel an enrollment includes the coverage plan, the enrollment period, and an enrollment end reason code with a value of “invalid entry.” Upon receipt of an enrollment cancellation, DEERS will cancel the PCM selection information. Once an enrollment is cancelled, it will not be returned in any future response from DEERS.

The following is a sample illustration of an enrollment cancellation. (For this illustration, assume the current date is 3/1/99.)

Figure 30. Enrollment Cancellation Example

5.3.7.7 Disenrollment Cancellation

Disenrollment Cancellations cannot be performed on DEERS assigned coverage plans or disenrollments done by DEERS due to loss of eligibility. A disenrollment cancellation can only be done by the entity that performed the disenrollment. The Disenrollment

Cancellation can only be done for the last enrollment period and must be performed within 60 days of the enrollment end date. Upon receiving a Disenrollment Cancellation, DEERS will reinstate the original enrollment period, including PCM selections, as it existed prior to the disenrollment. DEERS will notify the appropriate systems of the reinstatement of enrollment due to cancellation of the disenrollment.

In the split enrollment situation and depending on the type of disenrollment, (e.g., failure to pay fees) DEERS may also reinstate the enrollment for the beneficiaries in the other region(s) and notify the appropriate systems managing the enrollment.

The information necessary to cancel a disenrollment includes the coverage plan, the enrollment period, and an enrollment end reason code with a value of “not terminated.” Refer to Appendix E, Examples, for more information on cancellation events.

The following is a sample illustration of the cancellation of a disenrollment. (For this illustration, assume the current date is 3/1/99.)

Figure 31. Disenrollment Cancellation Example

The information required for the enrolling organization to cancel an enrollment or disenrollment is displayed in the following diagram.

Figure 32. Enrollment/Disenrollment Cancellation

5.3.8 Enrollment Fees and Enrollment Fee Waivers

DEERS will support several enrollment-fee-related transactions:

- Enrollment Fee Payment
- Enrollment Fee Payment History
- Update Individual Enrollment Fee Waiver Information

5.3.8.1 Enrollment Fee Payment

Enrollment fees are required for the following coverage plans:

- TRICARE Prime Individual Coverage for Retired Sponsors and Family Members
- TRICARE Prime Family Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Individual Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Family Coverage for Retired Sponsors and Family Members
- CHCBP Individual Coverage

- CHCBP Family Coverage

Enrollment fees may be paid monthly, quarterly, or annually. The beneficiary specifies this payment option during enrollment and the MCSC may send the fee information to DEERS as part of the enrollment transaction. To send DEERS fee information separate from the enrollment, MCSCs should use the Enrollment Fee Payment transaction. This event should also be used to update DEERS with subsequent enrollment fee payments for a policy when the quarterly or monthly option is selected, or to update a fee paid-through date if there is a change in the enrollment period. The subscriber's DEERS Id, policy, and enrollment fee payment information are required when performing this transaction. DEERS will keep track of the last HCDP Enrollment Fee System and accumulated enrollment fee payment information by policy for the enrollment year.

DEERS records both the enrollment fee payment date and the enrollment fee paid-through date sent with the notification. The enrollment fee paid-through date reflects the time period for which coverage is paid. The date represents neither when the enrollment fee payment information was received nor when it was sent to DEERS. The purpose of tracking what period an enrollment fee covers is portability. DEERS will record enrollment fee payment information and return accumulated enrollment fee payment information by policy for the enrollment year.

DEERS will not prorate fees, determine the amount of the next enrollment fee payment, determine the date of the next enrollment fee payment, send enrollment fee payment due notifications, identify what entity is responsible for enrollment fee payments, or automatically apply enrollment fee payments to catastrophic cap accumulations. These actions are the responsibility of the enrolling organization.

Under certain circumstances, enrollment fees may not be required because the catastrophic cap amount has been met or an enrollment fee payment is waived for an individual. If the catastrophic cap amount has been met for the family, no further enrollment fee payment or partial enrollment fee payment may be collected for the remainder of that enrollment period. This non-payment fee information should be sent to DEERS indicating the catastrophic cap was met for this period. In the same way, an enrollment fee payment may be less than the amount expected for the coverage plan because there is an individual in the policy who is exempt from paying fees due to a waiver. The reason for a partial or non-payment of enrollment fee information would be sent to DEERS using the HCDP Enrollment Fee Payment Exception Reason Code. It is necessary for DEERS to have this information for portability. This transaction could be used to send the partial payment or no payment of enrollment fees.DEERS will not track enrollment fee payment notifications for CHCBP.

Enrollment fees are not required for the following coverage plans:

- TRICARE Prime Individual Coverage for Active Duty Sponsors
- TRICARE Prime Individual Coverage for Active Duty Family Members
- TRICARE Prime Family Coverage for Active Duty Family Members
- TRICARE Prime for Survivors of Active Duty Deceased Sponsors

- TRICARE Prime Individual Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE Prime Family Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE Remote for Active Duty Sponsors
- TRICARE Remote Individual Coverage for Active Duty Family Members
- TRICARE Remote Family Coverage for Active Duty Family Members
- TRICARE Senior Prime Individual Coverage for Retired Sponsors and Family Members
- TRICARE USFHP Individual Coverage for Active Duty Family Members
- TRICARE USFHP Family Coverage for Active Duty Family Members
- TRICARE USFHP Individual Coverage for Transitional Assistance Sponsors and Family Members
- TRICARE USFHP Family Coverage for Transitional Assistance Sponsors and Family Members

5.3.8.1.1 Split Enrollments and Enrollment Fee Payment

DEERS supports split enrollments which occur when all family members are covered under the same policy and do not reside in the same geographic location, causing the policy to be administered by multiple regions. In addition, the enrollment fees may be collected from several locations for a single policy in a split enrollment situation. DEERS will accept and store enrollment fee payment notifications from multiple locations. DEERS will not identify or determine the entity or location responsible for the enrollment fee collection.

The following diagram details an Enrollment Fee Payment.

Figure 33. Enrollment Fee Payment

5.3.8.2 Enrollment Fee Payment Transaction History Request

Enrollment fee payments are collected for a policy during an enrollment period. DEERS will return cumulative enrollment fee payment information in response to eligibility and coverage inquiries. DEERS stores individual fee payment information for a policy and its corresponding enrollment period. The Enrollment Fee Transaction History Request will allow entities to review the individual enrollment fee payments that DEERS has recorded for a policy.

Enrollment fees are collected for the policy at the subscriber level. Therefore the information necessary to inquire on the enrollment fees for a policy include the subscriber's identification, the policy, and the anniversary date for the policy. DEERS will include all enrollment fee payment notifications received for the policy, including each payment amount, payment dates, and the entity that provided the information.

The following diagram illustrates an Enrollment Fee Payment Transaction History Request.

Figure 34. Enrollment Fee Payment Transaction History Request

5.3.8.3 Enrollment Fee Waiver Update for an Individual

Under certain circumstances, enrollment fees may be fully or partially waived. Fee waivers should not be confused with non-payment of enrollment fees due to meeting catastrophic cap amounts. Enrollment fee waivers are associated at the individual beneficiary level and should be sent to DEERS by the MCSC. For example, if three family members are waived from paying enrollment fees, an enrollment fee waiver must be applied to each person individually. The waiver information is a reason that indicates that there is a waiver during an enrollment period. There are no dates associated with the enrollment fee waiver and waiver information can be updated at any time during the enrollment period. This business event allows for an enrollment fee waiver to be applied to an individual or for an update to an existing enrollment fee waiver. Individual fee waiver information will be returned in the Eligibility for Enrollment Inquiry. The fee payment waiver status for an individual is used to distinguish between enrollment fees that were waived versus ones that were not paid. If a family is disenrolled due to failure to pay enrollment fees, and there is an individual family member with an enrollment fee waiver, that individual cannot be disenrolled, because he or she is exempt from paying fees.

Note: The concept of enrollment fee waivers is an unfunded new requirement.

The following diagram details an Enrollment Fee Waiver Update for an Individual.

Figure 35. Enrollment Fee Waiver Update for an Individual

5.4 General Updates

General updates include changes to both beneficiary and patient information. There are two business events: beneficiary updates, done by MHS personnel, including MCSCs; and patient updates, done by MHS clinical systems. MHS clinical systems can update both beneficiary and patient information in the DEERS database.

Obtaining SSNs for both sponsors and family members is important for correct person identification. However, DoD Personnel policy allows only verifying officials from personnel sources to update SSNs. For beneficiaries, only verifying officials can add SSNs. For non-DoD affiliated patients, the MHS clinical system can add the SSN.

DEERS receives address information from a number of source systems. The residence mailing address captured on DEERS is primarily used for EBC within the DoD for the delivery of medical care to the entitled population. A beneficiary update is used to update the *residence* mailing address.

In addition to the residence mailing address, a person may have a *correspondence* mailing address. A correspondence mailing address can be a post office box. This address is used for mailing notifications of changes to benefits and other directed mailings when a residence mailing address is not available. This address is not used to identify a physical location for EBC.

When an inquiry is performed, the residence mailing address is returned by DEERS, unless a residence mailing address is not available for the beneficiary requested. When a residence mailing address is not available, DEERS will return the *correspondence* mailing address. The Mailing Address Type Code identifies the address as either a residence mailing address or a correspondence mailing address. MHS and MCSC systems may update the address information as necessary. If DEERS returns a correspondence mailing address to the MHS and MCSC systems, it indicates that a residence mailing address is not in DEERS and the MHS and MCSC systems can add a residence mailing address.

DEERS has several types of telephone numbers for a person (e.g., home, work, and fax). These telephone numbers can be added and updated as necessary by the MHS and MCSC.

5.4.1 Beneficiary Updates

DEERS will allow MHS personnel to update beneficiary address and telephone number information for sponsors and family members in the DEERS database. In order to update an address or telephone number, the DEERS Id is required. If the DEERS Id is not available, it may be obtained through an eligibility or coverage inquiry.

Once the correct beneficiary is identified, the DEERS Id must be used to make changes to addresses and telephone numbers. An inquiry to DEERS is not required prior to address and telephone number updates, as long as the DEERS Id is sent. Enrolling organizations may only update mailing address and telephone number information.

The following diagram details a Beneficiary Update.

Figure 36. Beneficiary Update

5.4.2 Patient Adds and Updates

5.4.2.1 Patient Add

DEERS will allow MHS clinical systems to add a patient when the person is not affiliated with the Uniformed Services. This information will be tracked in DEERS in support of the Master Patient Index (MPI) when it becomes available.

A Patient Add event is similar to a Patient Update event, except the MHS does not have the DEERS provided Patient Id. Patients are added using the Person Id (i.e., SSN in this instance). If the submitted SSN matches an SSN already stored on DEERS, DEERS will create a Temporary Id which it will return to the MHS clinical system, indicating that the submitted SSN could not be stored due to duplication. DEERS will also send the Patient Id to the MHS in response to the Patient Add information and event, as shown below.

Figure 37. Patient Add

5.4.2.2 Patient Update

DEERS will allow patient updates by MHS clinical systems, including adding new information or updating existing information. Once the correct patient is identified, the Patient Id must be used to make changes to patient information. A coverage inquiry is not required prior to patient updates.

Possible patient updates include:

- Updating or adding ABO blood group and Rh type (refer to the explanation below for an understanding of the hierarchy to update ABO blood group and Rh type)
- Updating or adding organ donor information
- Adding date of death information for a patient
- Updating address and telephone number changes, including effective date of address

An ABO blood group and Rh type for a patient can come in from multiple data sources. Updates are managed by the following hierarchy of authority for the data:

- Personnel can input when a blood type does not exist during DoD ID card issue process, but cannot update data input by a medical source
- An MTF can input or update as necessary as a result of clinical processes but cannot update data input by the Defense Blood Standard System (DBSS)
- The DBSS can input or update all other source data input.

No other sources of ABO blood group and Rh type have been identified for input and update into DEERS.

Refer to Appendix F, Business Rules Matrix, for specific information about adding or updating patient events.

The following diagram identifies the information sent to DEERS for updating patient information.

Figure 38. Patient Update

5.5 Catastrophic Cap and Deductible Data

DEERS provides HCDP information for DoD-eligible sponsors and their family members. DEERS will store catastrophic cap and deductible data in a central repository. The purpose of the DEERS catastrophic cap and deductible repository is to maintain and provide accurate catastrophic cap and deductible amounts, making them universally accessible to DoD claims-processing agencies. Catastrophic cap and deductible amounts will be tallied for both individual and family policies, based on participation in the following HCDPs:

- TRICARE Standard
- TRICARE Prime (including Point of Service)
- Continued Health Care Benefit Program (CHCBP)

DEERS will support both batch and online transactions for coverage inquiries, catastrophic cap and deductible totals inquiries, and catastrophic cap and deductible updates from MCSCs.

5.5.1 Business Events

The types of business events regarding the DEERS catastrophic cap and deductible repository include:

- Customer service requests (accessing catastrophic cap and deductible balances)
- Claims processing (accessing. locking, and updating catastrophic cap and deductible balances)
- Catastrophic cap and deductible detail history requests

DEERS will support catastrophic cap and deductible history requests for claims processing. Refer to the Catastrophic Cap and Deductible Transaction History Request section for more information.

Customer service requests and claims processing are similar in that they both must correctly identify the beneficiary and verify coverage before querying for catastrophic cap and deductible balances. In order to update the catastrophic cap and deductible amounts, the totals must be locked appropriately.

The logical flows of these events are depicted and described in the following diagram.

Figure 39. Claims Processing Flow

The following list describes the steps in the flow diagram above:

1. The MCSC will query DEERS for coverage, which includes enrollment information if applicable.
2. The MCSC will query DEERS for catastrophic cap and deductible accumulations. If the MCSC is performing a customer service request, this is the final step. If the MCSC is processing a claim with intent to update the catastrophic cap and deductible amounts, a lock must be placed on the subscriber's family records, in order to adjudicate the claim.

   Note: The exception to the family members who are locked out is the unremarried former spouse, who is technically not part of the family group. The unremarried former spouse has his or her own policy and therefore acts as his or her own subscriber.
3. The MCSC can query DEERS as necessary in order to receive posted catastrophic cap and deductible details for a specified period. The MCSC adjudicates the claim and determines the catastrophic cap and deductible amounts to apply.
4. The MCSC updates the catastrophic cap and deductible amounts and sends these amounts to DEERS to store in the catastrophic cap and deductible repository for the appropriate coverage plan and service period. At this time, the MCSC chooses to remove or not remove the lock. Updates can be either positive or negative amounts. Positive amounts equate to additions or adjustments and negative amounts equate to adjustments or cancellations, as appropriate.

5.5.2 Data Events: Inquiries and Responses

This section identifies the main events, including the inquiries and responses between the MCSCs and DEERS, associated with catastrophic cap and deductible transactions.

Coverage verification should be performed before catastrophic cap and deductible amounts are updated. The main events to support processing this information include:

- Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity
- Catastrophic Cap and Deductible Totals Inquiry
- Catastrophic Cap and Deductible Amounts Update
- Catastrophic Cap and Deductible Transaction History Request

5.5.2.1 Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity

The DEERS Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity supports business events associated with health care coverage and catastrophic cap and deductible data for processing medical and pharmacy claims. There are multiple options for inquiring about coverage information while including catastrophic cap and deductible information. These different inquiry options allow the inquirer to receive coverage information and catastrophic cap and deductible totals with or without locking the catastrophic cap and deductible information for the family. An inquiry and locking of the

catastrophic cap and deductible accumulations is necessary prior to updating this data on DEERS. Therefore, both the Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity and the Catastrophic Cap and Deductible Totals Inquiry include a locking option to specify whether or not DEERS should lock the catastrophic cap and deductible amounts.

5.5.2.1.1 Pharmacy Claims Process using the Coverage Inquiry

The participating pharmacy submits information about the medicine prescribed, the prescription quantity, and the prescribing physician information. The prescription detail information is used by the pharmacy claims manager and is not passed to DEERS. The pharmacy claims manager passes the required DEERS coverage inquiry for claims information to the servicing MCSC, and the MCSC passes the coverage inquiry information to DEERS. The DEERS coverage response is returned to the MCSC, who verifies the OHI and catastrophic cap and deductible totals and returns the information to the pharmacy claims manager. The pharmacy claims manager verifies the prescription information, including the cost, and passes a response to the participating pharmacy indicating eligibility, appropriateness of the prescription, and cost share information.

Currently, DEERS does not have direct communication with the pharmacy claims manager. Pharmacy claims are handled via communication between the pharmacy claims manager and the MCSC. The MCSC communicates with DEERS. Therefore, DEERS will not allow pharmacy systems to lock and update catastrophic cap and deductible information.

5.5.2.1.2 Information Required for a Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity

The information needed to perform this type of coverage inquiry includes:

- Person identification information, including person or family transaction type
- Begin and end dates for the inquiry period
- Catastrophic cap and deductible lock option

5.5.2.1.2.1 Person Identification

A beneficiary's information is accessed with the coverage inquiry using the Person Id (SSN, Foreign National Id, or Temporary Id), last name, and date of birth (last name and date of birth are optional but recommended).

5.5.2.1.2.2 Inquiry Options: Person or Family

The inquirer must specify if the coverage inquiry is for a person or the entire family. The person inquiry option should be used when specific person identification is known. If person information is incomplete, the family inquiry mode can be used. In family inquiries, the Person Type Code is required to indicate if the SSN, Foreign Id, or Temporary Id is for the sponsor or family member. In such inquiries, DEERS will return both sponsor and family member information. If there is more than one person or family match, the correct person must be selected, then the coverage inquiry re-sent. Refer to the Duplicate Person Identification section for more information.

5.5.2.1.2.3 Inquiry Period

In addition to identifying the correct person or family, the inquirer must supply the inquiry period. The inquiry period may either be a single day or span multiple days, and historical dates are valid, as long as the requested dates are within three years of loss of eligibility. The inquirer queries DEERS for information about the coverage plans in effect during that inquiry period for the sponsor and/or family member. The reply may include one or more coverage plans in effect during the specified period or contain no coverage plan, meaning the beneficiary was ineligible for benefits for the specified time period.

5.5.2.1.2.4 Catastrophic Cap and Deductible Lock Option

The inquirer must indicate whether or not to place a lock on the catastrophic cap and deductible information. Refer to the Catastrophic Cap and Deductible Totals Inquiry section for additional information on catastrophic cap and deductible totals and locking.

DEERS will only return person information if the inquirer elects to lock the catastrophic cap and deductible totals with the coverage inquiry; there is not more than one person or family match; and the person has only one DEERS Id. The inquirer must then select the correct person and inquire again to get the coverage information and lock the totals. If there is a multi-person match, or the person has multiple DEERS Ids, the locking of the catastrophic cap and deductible totals must be done separately from the coverage inquiry. Refer to the Duplicate Person Identification section for more information.

5.5.2.1.3 Information Returned in the Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity

The different responses that DEERS could return for this inquiry include:

- Coverage with Catastrophic Cap and Deductible Totals: DEERS would return coverage and totals information. If the totals are presently locked, DEERS would also include lock information in the response, even though a lock was not requested in the inquiry.
- Coverage with Catastrophic Cap and Deductible Totals and Lock Information: DEERS would return coverage information, applicable totals, and lock information, if the inquirer specified to include and lock totals in the coverage inquiry, only if the totals were not presently locked.
- Coverage with Lock Information Only -No Catastrophic Cap and Deductible Totals: DEERS would only return coverage and lock information if the inquirer specified to include and lock totals and the beneficiary's information was already locked. No totals would be returned in this case, because the totals were presently locked.

The DEERS Id is returned in response to a coverage inquiry. The MCSC should retain the DEERS Id for use in subsequent transactions, including catastrophic cap and deductible totals inquiries and updates. The DEERS Id ensures correct person identification. In addition, the Patient Id will be returned in the coverage response. The Patient Id will be used for uniform person identification and patient identification required for the Health Care Service Record (HCSR).

5.5.2.1.3.1 Data Returned in a Coverage Inquiry That Repeats For Every Coverage Plan

In response to a Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity, DEERS returns the specified coverage information in effect for the inquiry period. The following list shows the information DEERS returns for each coverage plan in effect during the inquiry period:

- Coverage plan information (assigned or enrolled)
- Coverage plan enrollment status
- Coverage plan begin and end dates for inquiry period
- Sponsor personnel information (active duty, retired, pay grade, pay plan, etc.) and family member relationship to the sponsor during coverage period

5.5.2.1.3.2 Data Returned in a Coverage Inquiry Independently From the Coverage Plan Information

The DEERS coverage response could include PCM, OHI, OGP, and NAS information, and catastrophic cap and deductible totals and lock information, independently from the health care coverage information. If no OHI, OGP, or NAS information is returned, this means that DEERS does not have this information in effect for the requested inquiry dates.

- Primary care manager information: PCM information will be returned for each coverage plan that has an enrollment. No PCM information is present for the DoD-assigned coverage plans.
- Other Health Insurance: Limited OHI information will be returned. To receive additional OHI information, the inquirer may send a separate OHI inquiry.
- Other Government Programs: Complete OGP information will be provided in the response. OGPs include CHAMPVA and Medicare.
- Nonavailability Statements: Limited NAS information will be provided in the coverage response. Both active and cancelled NAS information will be returned, if the NAS issue date was within the requested coverage dates. To receive additional NAS information, the inquirer may send a separate NAS inquiry.
- Catastrophic cap and deductible totals: Both family and individual catastrophic cap and deductible accumulations will be provided in the coverage response. If a lock was requested and the information was already locked, DEERS will not return the catastrophic cap and deductible accumulations.
- Catastrophic cap and deductible lock option: Lock information is always returned with the coverage and catastrophic cap and deductible accumulation information when a lock is requested or exists.

5.5.2.1.4 Multiple Responses to a Single Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity

DEERS may need to send multiple responses to a single Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity, and these responses will be returned in a single transaction. This situation could occur if a person has multiple DEERS Ids within the inquiry period. It is necessary for DEERS to capture family member entitlements and benefit coverage corresponding to each instance of the person's DEERS Id. For example, in a joint service marriage, a child may be covered by the mother from January through May (DEERS Id #1) and covered by the father from June through December (DEERS Id #2). The child should not have dual coverage under both the mother and the father concurrently.

The following diagram depicts the data elements within the Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity.

Figure 40. Health Care Coverage Inquiry for Catastrophic Cap and Deductible Activity

5.5.2.2 Catastrophic Cap and Deductible Totals Inquiry

The Catastrophic Cap and Deductible Totals Inquiry is used to obtain catastrophic cap and deductible balances for the fiscal year(s) and enrollment year(s) that correspond to the requested inquiry period. The MCSC must inquire and lock catastrophic cap and deductible totals before updating DEERS catastrophic cap and deductible amounts.

5.5.2.2.1 Information Required to Inquire for Totals

5.5.2.2.1.1 Person Information

The MCSC must have the DEERS Id for this inquiry. If the MCSC does not have the DEERS Id, it may be obtained from a coverage inquiry transaction. Either the sponsor's or family member's DEERS Id is used for the totals inquiry. Even though only one person's DEERS Id is used, both individual and family totals will be returned in the response.

5.5.2.2.1.2 Catastrophic Cap and Deductible Totals Inquiry Period

The inquiry period used for the Catastrophic Cap and Deductible Totals Inquiry may be a single date or a date range, not more than three years past loss of eligibility. Future dates are not valid.

5.5.2.2.1.3 Lock Indicator

The MCSC chooses whether to lock catastrophic cap and deductible totals. However, if the MCSC intends to update the catastrophic cap and deductible amounts, the MCSC must lock the catastrophic cap and deductible totals in order to adjudicate the claim.

DEERS will maintain locks on catastrophic cap and deductible data as needed for catastrophic cap and deductible totals and updates. When the MCSC indicates that they would like to place a lock, the MCSC must provide a claim identifier, enrollment fee identifier, or adjustment identifier. DEERS refers to this as the Catastrophic Cap and Deductible Detail Id, and the Catastrophic Cap and Deductible Detail Type Code indicates the type of update being made. This identifier is used for locking and will be checked against the identifier used for updating the catastrophic cap and deductible amounts. The source of the lock, the lock date, and the lock time will be derived by DEERS.

DEERS will support the following lock functionality:

- No Lock – No lock is in place.
- Lock – All MCSCs other than the MCSC organization that placed the lock will be locked out. Only the MCSC organization that initiated the lock is able to access and update totals, and the detail identifier used for locking must match the detail identifier used for updating.

The claims lock period is 48 hours or until the lock is released, whichever comes first. If the MCSC needs more than 48 hours to adjudicate the claim, they may extend the lock by performing another catastrophic cap and deductible total inquiry to lock a locked record. When this happens, a new lock date and time will be set. Only the same locking organization that placed the lock may extend the lock, and only if the catastrophic cap and

deductible detail update identifier matches the identifier used to initially lock the record. DEERS will not support a separate "continue lock" feature.

Note: A lock is placed on the subscriber's family catastrophic cap and deductible records. The family is made up of the subscriber and all associated family members.

5.5.2.3 Response to Catastrophic Cap and Deductible Totals Inquiry

5.5.2.3.1 Catastrophic Cap and Deductible Totals

DEERS sends a response showing year-to-date catastrophic cap and deductible totals for each HCDP (e.g., TRICARE Standard, TRICARE Prime, and CHCBP) as necessary. Based on the inquiry dates requested, DEERS will determine the appropriate fiscal year and the enrollment year and return the totals for these respective periods within each HCDP. Both individual and family totals are displayed, showing catastrophic cap and deductible balances separately. If there are no catastrophic cap and deductible totals accumulated for the inquiry period requested, DEERS will show a zero value.

If the inquiry period spans fiscal or enrollment years, the catastrophic cap and deductible totals would repeat multiple times. For example, if the inquiry dates are September 1, 1998 through October 25, 1998, there would be two sets of fiscal year totals, one for FY 1998 and one for FY 1999. If the beneficiary had an enrollment anniversary date of October 1, there would also be two sets of enrollment year totals.

5.5.2.3.2 Lock Information

If an MCSC inquires for catastrophic cap and deductible totals and does not place a lock on the totals, DEERS would return any totals accumulated for the inquiry period and lock information if the totals were presently locked. If an MCSC inquires for totals with a lock and the totals were not presently locked, DEERS would return the accumulated totals and that MCSC's lock information, including their lock organization, lock date, and lock time. If an MCSC inquires and locks catastrophic cap and deductible totals for a beneficiary whose totals are already locked, only the lock organization, lock date, and lock time will be returned. No totals will be returned in this situation.

The following diagram depicts a Catastrophic Cap and Deductible Totals Inquiry.

Figure 41. Catastrophic Cap and Deductible Totals Inquiry

5.5.2.4 Updating Catastrophic Cap and Deductible Amounts

After a coverage inquiry is performed and catastrophic cap and deductible totals are checked and locked, an MCSC may update DEERS catastrophic cap and deductible amounts. As mentioned previously, DEERS will not accept updates from pharmacy systems. This update transaction requires the DEERS Id, which may be obtained from a coverage inquiry. Only the same organization that placed the lock may update the locked record and remove the lock. DEERS validates that the updating organization is the same as the organization that placed the lock. If there is a discrepancy, DEERS will not allow the update and will send a notification that the update was not successful. If there are more claims outstanding for the same family, the MCSC may choose not to remove the lock. In this case, the record would remain locked until the 48-hour time period expires, or the lock is removed, whichever comes first.

Catastrophic cap and deductible amounts can be updated online for the previous three years. However, this time period may be less, depending on eligibility. In addition, each transaction should only include updates for one claim. This means that catastrophic cap and deductible amounts for multiple claims should be sent in separate transactions. However, in the split claim situation, multiple updates for the same claim can be included in one transaction. For example, if a claim spans fiscal years and is split, updates for FY 1988 and FY 1999 can be sent in one transaction because the claim extension identifier (explained below) would distinguish the two updates from one another.

5.5.2.4.1 Information Required to Update Catastrophic Cap and Deductible Amounts

The MCSC must provide the following information to update the catastrophic cap and deductible amounts:

- DEERS Id: This identifies the beneficiary for whom the update is applied.
- Specification of fiscal or enrollment year category to which the update applies
- Health care delivery program (e.g.,TRICARE Standard, TRICARE Prime, CHCBP)
- Catastrophic cap, deductible, and/or point of service dollar amount
- Identifier for the claim, enrollment fee, or adjustment

  Note: If there is a discrepancy between the identifier used for locking and the identifier used for updating, DEERS will not allow the update.

- Claim extension identifier

  When a claim spans fiscal or enrollment years, the claim extension is used to identify a split claim. These claims should have the same claim identifier with a different claim extension identifier. Splitting the claim is the responsibility of the claims processor, who splits the claim, adds the claim extension, and sends this information to DEERS.

- Lock information (remove or do not remove lock)The MCSC sends DEERS the catastrophic cap and deductible amount for the beneficiary. DEERS knows to which family the beneficiary belongs and will roll up the totals for the correct family using the DEERS Id.

- Dates provided for the catastrophic cap and/or deductible update.

  The dates may include the date(s) of service for the claim (both begin and end date), the fiscal year and an enrollment calendar date within the claim period of service, appropriately. These dates are necessary for accumulating the catastrophic cap and deductible totals for the correct time period and HCDP.

  - For fiscal year updates, the MCSC must send DEERS the fiscal year for which the catastrophic cap and deductible applies.
  - For enrollment year updates, the MCSC must send DEERS a calendar date within the enrollment period to which the catastrophic cap and deductible applies.
  - For updates associated with a claim, the period of service for the claim should be sent to DEERS, so that the information can be referenced with catastrophic cap and deductible details.

5.5.2.4.2 Types of Catastrophic Cap and Deductible Updates

DEERS will support catastrophic cap and deductible update functionality including adding, adjusting, and canceling amounts. Adds, adjustments, and cancellations may be made for the previous three years.

- Adds

  The MCSC utilizes the catastrophic cap and deductible update to add new catastrophic cap and deductible amounts to the DEERS catastrophic cap and deductible repository.

- Adjustments

  The MCSC utilizes the catastrophic cap and deductible update to adjust posted catastrophic cap and deductible amounts. The same claim identifier as the original claim must be provided for the adjustment. A negative or positive amount should be entered, in order to correct the net amount. In order to adjust a claim, an MCSC must provide the same information for updating a claim as outlined in the previous section. For example, an MCSC updates a claim with a $50 catastrophic cap amount, then two weeks later discovers that the claim was incorrectly adjudicated and the catastrophic cap amount should have been $35. The MCSC would then update the beneficiary's catastrophic cap for the same claim number with an amount of -$15. The DEERS catastrophic cap balance would then show $35 for that claim.

- Canceling a catastrophic cap or deductible amount

  The MCSC utilizes this update transaction to cancel (zero out a posted amount) a previously submitted catastrophic cap or deductible amount.

  Claim cancellations will be handled similarly to adjustments. For example, an MCSC updates a claim with a $120 deductible amount, then one week later discovers that this was incorrect, and there should not have been any adjudicated deductible amount. The MCSC would then update the insured's deductible with an amount of -$120. This would zero out the previous amount applied for that claim.

- The 48-hour rule

  DEERS will enforce a 48-hour lockout rule. If an MCSC places a lock on a record and fails to update that record within the specified 48-hour time period, the MCSC will be unable to update catastrophic cap and deductible amounts, because the lock will have expired.

- Removing a lock

  If an MCSC places a lock, then realizes the lock is unnecessary, the preferred way to remove that lock is to perform a catastrophic cap and deductible update specifying to remove the lock. In this case, the MCSC would send no catastrophic cap or deductible amounts, only indicate the removal of the lock.

5.5.2.5 Response to Updating Catastrophic Cap and Deductible Amounts

DEERS will send an acknowledgement message after a successful catastrophic cap and deductible update.

The following diagram details a Catastrophic Cap and Deductible Amounts Update.

Figure 42. Catastrophic Cap and Deductible Amounts Update

5.5.3 Catastrophic Cap and Deductible Transaction History Request

Catastrophic cap and deductible transaction history information is useful for customer service requests, for auditing purposes, or for resolving any problems associated with catastrophic cap and deductible updates in relation to a particular claim. DEERS will maintain a record of each update transaction applied toward catastrophic cap and deductible information. This detailed transaction information will be available through the catastrophic cap and deductible transaction history request. The following transaction history request types are available:

- Specific family member or beneficiary
- Fiscal year or inquiry period (begin and end month/year)
- Specific detail identifier (claim number, enrollment fee, or adjustment)

5.5.3.1 Information Required to Request a Catastrophic Cap and Deductible Transaction History

The required information for a transaction history request includes:

- Person identification information, including person or family transaction type
- Health care delivery program
- Fiscal year or inquiry period begin and end dates
- Detail identifier (claim, enrollment fee, or adjustment), optional if interested in a specific update

5.5.3.1.2 Person Identification Information

A beneficiary's information is accessed in the transaction history request using either the DEERS Id or the Person Id (SSN, Foreign National Id, or Temporary Id), last name, and date of birth (last name and date of birth are optional but recommended).

5.5.3.1.2 Person or Family Transaction Type

The inquirer must specify if the transaction history inquiry is for a person or the entire family. In family inquiries, DEERS will return both sponsor and all associated family members. With family inquiries, the Person Type Code is required to indicate if the person identification information is for the sponsor or family member. If there is more than one person or family match, the correct person or family must be selected, then the transaction history request re-sent. Refer to the Duplicate Person Identification section for more information.

5.5.3.1.3 Inquiry Period

In addition to supplying person identification information and requesting a person or family transaction, the inquirer must provide the inquiry period. The inquiry period may be either a fiscal year or a date range. Historical dates are valid, as long as the requested dates are within three years past loss of eligibility.

5.5.3.1.4 Detail Identifier

If requested, the inquirer may query for catastrophic cap and deductible transaction history information for a specific update using the detail identifier. The detail identifier corresponds to the claim number, enrollment fee identifier, or adjustment identifier used for posting the catastrophic cap and deductible amounts. When the inquirer specifies a detail identifier for the inquiry, DEERS will return only catastrophic cap and deductible updates that match that detail identifier.

5.5.3.2 Information Returned in Response to a Catastrophic Cap and Deductible Transaction History Request

DEERS will return each individual catastrophic cap and deductible amount that was applied to the inquiry period for the specified person or family. Fiscal year and enrollment

year amounts will return as appropriate. Amounts returned in the response may include both positive and negative amounts.

> For example, if the inquiry period were Fiscal Year 1999, all catastrophic cap and deductible amounts that were applied to the FY 1999 will be returned in the transaction history response regardless of the date in which the update was actually sent to DEERS. DEERS does not use the transaction date to determine what detail to return in the response. DEERS uses the period to which the update actually applies.

If there is a lock currently placed on the catastrophic cap and deductible totals, the locking organization, lock date, and lock time will also return. In this way, the inquirer will know that there are claims in process for that family. DEERS will also return the detail identifying information used for each catastrophic cap and deductible posted update including the system that performed the update, the transaction date and time for each record. DEERS will not return accumulated totals in the response.

The following diagram details a Catastrophic Cap and Deductible Transaction History Request.

Figure 43. Catastrophic Cap and Deductible Transaction History Request

5.5.4 Catastrophic Cap and Deductible Data Transfer

TRICARE Standard catastrophic cap and deductible data has been maintained in the Central Deductible and Catastrophic Cap File (CDCF) since FY 1995 for claims with a date of service on or after October 1, 1994. This data will be ported from the CDCF to the DEERS catastrophic cap and deductible repository via initial load.

TRICARE Prime catastrophic cap and deductible data has been maintained separately by MCSCs. Because the TRICARE Prime data has not been stored centrally, the method by which this data will be transferred to the DEERS catastrophic cap and deductible repository is still under review.

5.5.5 Catastrophic Cap and Deductible Data Storage

DEERS will store catastrophic cap and deductible data both by beneficiary and by TRICARE program. For TRICARE Standard and Extra, DEERS will tabulate and store catastrophic cap and deductible balances by fiscal year, which is October 1 through September 30.

For TRICARE Prime and Point of Service, DEERS will tabulate and store catastrophic cap and deductible balances by enrollment year (based on the policy enrollment period) and fiscal year, as directed by the MCSC.

For CHCBP claims, DEERS will tabulate and store catastrophic cap and deductible balances by fiscal year.

DEERS will store catastrophic cap and deductible data indefinitely and archive it as necessary. The most recent three years of catastrophic cap and deductible data will be maintained online.

5.6 Referrals and Nonavailability Statements

DEERS centrally supports the issuing and tracking of Nonavailability Statements (NAS). DEERS will store each NAS for three years. When conditions arise at an MTF that require a beneficiary to seek care outside that facility, an NAS may be issued. (An NAS is not created for outpatient procedures.) Beneficiaries not enrolled in TRICARE Prime continue to require an NAS for civilian inpatient care, as referenced in Section 734 of the *National Defense Authorization Act for Fiscal Year 1997*. Since an NAS only pertains to a Direct Care facility, an NAS may only be issued via the interface with DEERS and CHCS. Once the NAS has been issued, a DEERS inquiry can be performed to view the NAS information while a claim is adjudicated.

DEERS will support NAS activities including issuance, inquiry, and cancellation. The requirement for issuing a conditional NAS has been removed and DEERS will not support this NAS activity. No updates can be performed once an NAS has been issued. If a person cancels an NAS, DEERS will not validate whether the individual is authorized to perform the event. This responsibility should be enforced by the facility. DEERS will, however, verify that the issuing facility is the same as the canceling facility. Prior to issuing an NAS, a coverage inquiry should be performed to ensure that the beneficiary is eligible for benefits. DEERS will verify that the coverage information is valid upon issuing an NAS. DEERS will assign a unique system-generated NAS Id that incorporates the issuing facility DMIS Id; validate the information entered for accuracy when issuing an NAS; and ensure that NAS Ids are maintained.

Once an NAS is issued, it can be printed at that time or re-printed at a later date. DEERS will supply the information for the NAS to be printed. The facility is responsible for printing the NAS and indicating if the NAS is a reprint. DEERS will not track how many times an NAS is printed. DEERS will not track the date that the NAS was created, but will track the issue date of the NAS for the purpose of issuing a NAS retroactively. The issue date represents when the NAS is effective.

When issuing an NAS for a beneficiary, if OHI information is in effect for the issue date, DEERS will set the OHI indicator. An OHI Inquiry should be used to specify or retrieve detailed OHI information.

DEERS will not accept address or telephone number changes when creating an NAS. The address of the beneficiary may directly impact the NAS information. If the beneficiary's address or telephone number is incorrect, it should be updated prior to issuing the NAS. Address and telephone number changes should be done using the Beneficiary Update transaction.

DEERS will add two new diagnostic categories, Multiple Significant Trauma and Human Immunodeficiency Virus Infections, for tracking treatments issued via an NAS. DEERS will also track two new patient categories, TAMP Sponsor and Family Member of TAMP Sponsor. This information will also be included in NAS reporting.

DEERS will also provide the following NAS reporting functionality:

- Facility monthly summary for the number of NAS issued for each diagnostic category by the reason for issuance. The issuance reasons are broken out into two groups, one by type of sponsor and the other by normal or retroactive status. This breakout produces two separate reports.
- Facility monthly summary for the number of NAS issued for each diagnostic category by the sponsor branch of service
- Branch of service facility monthly summary for the number of NAS for each diagnostic category by the reason for issuance. The issuance reasons are broken out into two groups, one by type of sponsor and the other by normal or retroactive status. This breakout produces two separate reports.
- Branch of service facility monthly summary for the number of NAS for each diagnostic category by the sponsor Branch of service.
- Since an NAS is not created for outpatient procedures, DEERS will not report NAS for outpatient procedures.

5.6.1 NAS Inquiry

5.6.1.1 Person Identification for NAS Inquiry

NAS information is requested using either Person Id (SSN, Foreign National Id, or Temporary Id) the DEERS Id or the Patient Id. If the request uses the Person Id, this request should also provide the person's date of birth and last name to prevent ambiguous results (last name and date of birth are optional, but recommended).

5.6.1.2 NAS Inquiry Options: Person or Family

The NAS inquiry requests information about an individual. DEERS will allow multiple NAS for a person.

5.6.1.3 Nonavailability Statement Information

There are several ways the requester can specify the NAS information for the inquiry. The requestor can specify a time period (begin and end date) or the specific NAS Id.

5.6.1.4 Information Returned in the NAS Inquiry Response

The NAS inquiry response will return the sponsor and the insured patient information along with the details of the NAS at the time it was issued. DEERS will return the person identification information sent in the inquiry. If the inquiry was done with the DEERS Id, DEERS will include the DEERS Id in the response. If the inquiry was done with the Patient Id, DEERS will include the Patient Id in the response. If the inquiry was done with the Person Id information, DEERS will return the Person Id information and will not send either the DEERS Id or the Patient Id.

The following diagram depicts an NAS Inquiry.

Figure 44. Nonavailability Statement (NAS) Inquiry

5.6.2 NAS Issuance

The Patient Id must be used when issuing an NAS. If the Patient Id is unknown, a Health Care Coverage Inquiry for MTFs can be done to obtain it. DEERS will derive the patient data from the Patient Id. DEERS will also derive the address and branch of service information from the issuing and/or medically inappropriate DMIS Id. The sponsor information for the patient and the relevant NAS information are required to be sent to DEERS. DEERS will generate the NAS Id using the issue date, NAS issue type, and the DMIS Id of the issuing facility. No OHI information is sent when issuing an NAS. DEERS will determine if OHI information is in effect at the time the NAS was issued and set an OHI indicator.

DEERS will support the following reasons for issuing an NAS:

- Proper facilities are temporarily not available in a safe or timely manner
- Professional capability is temporarily not available in a safe or timely manner
- Proper facilities or professional capability are permanently not available at this facility
- It would be medically inappropriate to require the beneficiary to use the MTF

  If an NAS is issued for a medically inappropriate reason, it should be further clarified using the following additional reason:

  - Temporarily away from permanent residence (TDY)
  - Permanent change of station status (PCS); between permanent duty assignments
  - Travel unreasonably difficult or costly
  - Other

DEERS will send an acknowledgment to the NAS issuance that includes the NAS Id, Patient Id, and the OHI indicator if OHI is in effect at the time of the NAS issuance.

The following diagram depicts an NAS Issuance.

Figure 45. NAS Issuance

5.6.3 NAS Cancellation

The Patient Id must be used when canceling an NAS. If the Patient Id is unknown, a Health Care Coverage Inquiry for MTFs can be done to obtain it. Canceling an NAS will set the NAS Cancel Date as the date of the transaction and the status of the NAS will be that of "cancelled." DEERS will validate that the facility canceling the NAS is the same facility that issued the NAS.

The following diagram depicts an NAS Cancellation.

Figure 46. NAS Cancellation

5.7 Other Health Insurance

Other Health Insurance (OHI) identifies non-DoD health insurance held by a beneficiary. The requirements for OHI are validated by the Uniform Business Office (UBO) and OASD (HA)/TMA--Resource Management (Financial Analysis and Integration). OHI information includes:

- OHI policy and carrier
- Policyholder
- Type of coverage provided by the additional insurance policy
- Employer information offering coverage, if applicable
- Effective period of the policy

OHI transactions allow adding, updating, canceling, or viewing all OHI policy information, as opposed to the limited OHI policy information returned with eligibility or coverage inquiries. OHI policy updates can accompany enrollments or be performed alone.

The Health Insurance Carrier Id, Other Health Insurance Policy Id, and OHI Effective Date cannot be updated once an OHI policy has been added to DEERS. These attributes, along with the person identification, uniquely identify an OHI Policy. The Health Insurance Carrier Id is associated with the DoD Standard Insurance Table (SIT). Refer to the SIT section for additional information.

DEERS recommends performing a coverage inquiry or an OHI Inquiry before attempting to add or update an OHI policy. DEERS is responsible for the accuracy of the OHI information on file; however, DEERS is reliant on the input source for the proper assignment of a policy to a person. To understand this better, a patient would not be added or updated without first requesting the information from DEERS. Performing a coverage inquiry or an OHI Inquiry on a person before adding or attempting to update an OHI policy will help ensure that the proper policy is updated, based on the most current information for the person.

DEERS will not track coordination of benefits priority because this information can change frequently and may not be accurate. DEERS will allow OHI coverage to be indicated for the following:

- Medical coverage
- Dental coverage
- Inpatient coverage
- Outpatient coverage
- Long-term care coverage
- Pharmacy coverage

- Mental health coverage
- Vision coverage
- Partial hospitalization coverage
- Skilled nursing care coverage

DEERS will report which coverage indicators are included within the OHI policy. In addition, each OHI policy will carry a code indicating whether the policy is active, inactive, or deactivated. The deactivation of an OHI policy only occurs when the health insurance carrier has been deactivated by the DoD SIT validation agency. Refer to the SIT section for more information. DEERS will retain an OHI policy for three years after it becomes inactive, is deactivated, or expires.

5.7.1 OHI Policy Inquiry

5.7.1.1 Person Identification for OHI Policy Inquiry

OHI information is requested using the DEERS Id or Patient Id. Person identification applies to the sponsor or family member. If the DEERS Id or Patient Id is unknown, a coverage inquiry to DEERS can be done to obtain it.

5.7.1.2 OHI Inquiry Options: Person or Family

The OHI data is by person and the OHI inquiry is only for individual person requests. DEERS will allow multiple OHI policies for each person. DEERS will not support an inquiry that shows all insureds in a particular policy.

5.7.1.3 OHI Information

There are multiple ways the requester can specify the OHI information for the inquiry. The requester can specify a time period (begin and end date) or through combinations of the time period, the Health Insurance Carrier Id, the OHI Policy Id and the OHI Coverage Indicator Type Code. The details about requesting OHI information are contained in the Appendix F, Business Rules Matrix.

The Health Insurance Carrier Id represents the Id assigned to insurance carriers in the SIT provided by the DoD to DEERS. If a requester is unsure about a specific OHI Policy Id, a time period should be specified for the inquiry. In addition, a requester can seek information on a specific coverage for a beneficiary by using the OHI Coverage Indicator Code in the OHI inquiry sent to DEERS.

5.7.1.4 Information Returned in the OHI Inquiry Response

The DEERS response will return all OHI policies in effect during the specified time period for the beneficiary. OHI policies that are inactive or deactivated will be returned if the OHI policies were in effect for any portion of the OHI inquiry period. If a specific

coverage type was selected in the inquiry, only policies having that coverage would be included in the DEERS response.

If DEERS cannot find the OHI policies for the specific coverage indicator, DEERS will not return any OHI policies for the requested OHI inquiry period. When the DEERS Id is included in the OHI inquiry, the DEERS Id will be returned in the response; when the Patient Id is included in the OHI inquiry, the Patient Id will be returned in the response.

The following figure depicts an OHI Policy Inquiry.

Figure 47. OHI Policy Inquiry

5.7.2 OHI Policy Add

DEERS will allow MHS and MCSC systems to add an OHI policy for a person when documented information is presented to the MHS clinical personnel or to the MCSC. A coverage inquiry or an OHI Policy Inquiry should be done prior to adding an OHI policy. This ensures that updates are performed with the most current information. Following the coverage inquiry or the OHI Policy Inquiry, the OHI data can be added as necessary.

The fields required to add an OHI policy for a person are:

- DEERS Id or Patient Id
- OHI Effective Calendar Date
- OHI Expiration Calendar Date
- Health Insurance Carrier Id
- OHI Policy Id
- OHI Policyholder Surname
- OHI Policyholder Forename
- OHI Policyholder Id
- OHI Policyholder Person Association Reason Code
- OHI Coverage Indicators for the policy

A person can have multiple OHI coverage indicators for one policy. For example, to add an OHI policy that covers medical and vision, two OHI coverage indicators, one for medical coverage and one for vision coverage, would be sent to DEERS.

The Health Insurance Carrier Id is associated with a verified insurer listed in the Standard Insurance Table (SIT). If there is no SIT entry for this health insurance carrier, a separate SIT transaction can be performed in which DEERS will provide a temporary Health Insurance Carrier Id to be used in the interim for the Health Insurance Carrier Id. Refer to the SIT section of this document for additional information.

When an MHS system is enrolling a person into a coverage plan, or another MHS organization is updating person or patient data without the full insurance claim submission information necessary to record the OHI policy information, there is a placeholder entry on the SIT that can be used to complete the process. The placeholder entry on the SIT has a value of “Unknown” and can be used to indicate that an OHI policy exists for a beneficiary. This health insurance carrier of “Unknown” has an assigned Health Insurance Carrier Id; although “medical” is the default coverage indicator, any coverage indicator can be assigned to it. Monthly, DEERS will provide the UBO and the entity which provided the policy a report of the persons with an “Unknown” OHI policy. The report will detail the persons’ information and the systems that entered the “Unknown” policy. The enrolling or updating system will be responsible for obtaining the complete OHI information.

Incomplete or inaccurate information insufficient to store an OHI policy for a person will be rejected by DEERS. All messages sent to DEERS will receive an acknowledgement accepting or rejecting the add or update.

The following diagram depicts an OHI Policy Add.

Figure 48. OHI Policy Add

5.7.3 OHI Policy Update

DEERSwill allow MHS systems to update existing OHI policy information for a person when documented information is presented. An OHI Policy Inquiry should be done prior to updating an OHI policy. This ensures that updates are performed with the most current information. Following the OHI Policy Inquiry, the OHI data can be updated as necessary.

The following fields are required to identify the OHI policy to be updated for a person, and cannot be changed:

- DEERS Id or Patient Id
- Health Insurance Carrier Id

- OHI Policy Id
- OHI Effective Calendar Date

All other fields associated with an OHI policy may be updated.

The following figure depicts an OHI policy Update.

Figure 49. OHI Policy Update

5.7.4 OHI Policy Cancellation

Cancellation of an OHI policy is done to disassociate an OHI policy from a person. *The OHI Policy Cancellation is not used to terminate an existing policy.* If the OHI policy exists for the person but some of the data is incorrect, it should be updated accordingly. An OHI policy cancellation will completely remove the policy. DEERS will verify that the cancellation is performed by the system that added or last updated the OHI policy.

When canceling an OHI policy, an OHI Policy Inquiry should be done to verify the information necessary to perform a cancel. Canceling an OHI policy requires the following data elements:

- Health Insurance Carrier Id
- OHI Policy Id
- OHI Effective Calendar Date
- OHI Expiration Calendar Date

The following figure depicts an OHI Policy Cancellation.

Figure 50. OHI Policy Cancellation

5.8 Standard Insurance Table

The Standardized Insurance Table (SIT) program supports the MHS billing and collection process. The requirements for the SIT are validated by the Uniform Business Office (UBO) and OASD (HA)/TMA--Resources Management (Financial Analysis and Integration). DEERS will be the central repository of the SIT information for MHS personnel use. The SIT will be maintained in DEERS by the verifying source established by the DoD on the advice of the TMA. The MHS personnel will use the SIT to obtain other payer information in a standardized format. The SIT provides a uniform billing contact for reimbursement of medical care costs covered through policies held by the DoD person population.

The Health Insurance Carrier Id is the key used for associating a person's OHI policy with an insurance company on the SIT. During the initial deployment of the DEERS medical initiative, the Health Insurance Carrier Id will consist of the first three letters of the insurance company name, the two-letter standard state abbreviation, and a two-character identifier assigned by the DoD SIT validation agency. Once HCFA assigns the national identifier, DEERS and trading partners will migrate to the identifier.

All systems identified as trading partners will be notified when the initial SIT is available on DEERS for download to their local systems. Systems identified to DEERS as authorized holders of a local copy of the SIT will be notified when updates are made to the SIT on DEERS. These updates may result from a user request that is validated by the DoD SIT validation agency, or may be additions or updates directly from the DoD SIT validation agency.

Field users can do four actions with the SIT:

- An inquiry action to verify the information in the table for assignment of an OHI policy or to verify billing information
- An add action to report a new SIT entry for validation by the DoD SIT validation agency.
- An update action to report an updated SIT entry for validation by the DoD SIT validation agency
- The cancellation of an update sent to the SIT for verification by the DoD SIT validation agency

5.8.1 SIT Inquiry

The inquiry can be done by submitting the Health Insurance Carrier Name and Health Insurance Carrier Type Code, if known, or by submitting the Health Insurance Carrier Name, the Health Insurance Carrier Mailing Address US Postal Region State Code, and the Health Insurance Carrier Mailing Address Country Code. Regardless of the type of inquiry, DEERS will return all matching carrier information resident on the SIT. If there are multiple matches, based on an incomplete carrier name, state, and country, DEERS will return a list of those carriers most closely fitting the inquiry.

The following diagram is an example of a SIT Inquiry.

Figure 51. SIT Inquiry

5.8.2 SIT Add

MHS personnel cannot add an OHI policy to a person or patient without a Health Insurance Carrier Id that matches an entry in the SIT, or a temporary Health Insurance Carrier Id provided by DEERS when the Health Insurance Carrier Id has not been verified by the DoD SIT validation agency. The Health Insurance Carrier Id represents the identifier assigned to insurance carriers in the SIT provided by the DoD to DEERS. The Health Insurance Carrier Id Type Code identifies the Id as permanent or temporary.

Addition of an OHI policy to a person or patient does not automatically generate a request for update to the SIT. A SIT update will post the updated carrier information to the DEERS SIT pending validation by the DoD SIT validation agency. A description of the validation process is in a later section.

When an OHI carrier is not on the SIT, the user may send a request to add it to the SIT on DEERS. DEERS will respond with a Health Insurance Carrier Id and a Health Insurance Carrier Id Type Code designation of "temporary." The temporary Health Insurance Carrier Id will track the SIT update. When the DoD SIT validation agency validates the SIT, the agency assigns the permanent Health Insurance Carrier Id. DEERS will send the permanent Health Insurance Carrier Id with the other appropriate health insurance carrier information to all local holders of the SIT. In addition, DEERS will update the DEERS temporary carrier identifiers with the permanent Health Insurance Carrier Id on the affected OHI policies in DEERS.

The following diagram is an example of a SIT Add.

Figure 52. SIT Add

5.8.3 SIT Update

For updates to an existing SIT record, the existing Health Insurance Carrier Id is sent with the update. Without the Health Insurance Carrier Id, DEERS will not be able to report a validation or a rejection of the SIT update. Returning all the insurer information in the update will assist the rapid validation of the SIT by the DoD SIT validation agency. For all SIT updates, DEERS will retain the system identifier of the site performing the update. The DoD SIT validation agency uses the system identifier to report a rejection of the SIT update to the submitting site only.

DEERS will not allow an update to a health insurance carrier with a temporary Health Insurance Carrier Id until validated or rejected by the DoD SIT validation agency. However, DEERS will allow the submitting site to cancel the update request prior to validation by the DoD SIT validation agency. See the SIT Add/Update Cancellation section for more information.

The following diagram is an example of a SIT Update.

Figure 53. SIT Update

5.8.4 SIT Add/Update Cancellation

MHS personnel may need to cancel a previously submitted update to the SIT requesting the add of a new health insurance carrier, or cancel an update to an existing health insurance carrier. A cancel can only be done by the system that submitted the update, and only if the update has not yet been verified by the DoD SIT validation agency. The MHS personnel need to perform a SIT inquiry to verify the Health Insurance Carrier Id of the entry to be cancelled, and ensure that the requested update is still unverified. After ensuring the unverified status of the Health Insurance Carrier Id, the MHS can send the SIT cancellation.

DEERS will cancel any OHI policy on the DEERS database associated with the cancelled health insurance carrier. After the update request is cancelled, DEERS will not make the cancelled update request available to all sites holding a local copy of the SIT, or to users with access to the central SIT on DEERS. The cancelled adds or updates will be available to the DoD SIT validation agency for review as necessary.

The following diagram is an example of a SIT Cancellation.

Figure 54. SIT Cancellation

5.8.5 Validation of Health Insurance Carrier Information

DEERS, under the guidance of the UBO and the OASD (HA)/TMA--RM (FA&I), is developing an application that will allow access to the SIT until the full system is available. The application allows site access to the SIT for inquiry, update or validation by the DoD SIT validation agency. After the full system is available, the application will continue to serve the DoD SIT validation agency as the mechanism to validate SIT add and update requests from local sites.

Validation of a SIT update includes verifying the name, mailing address, and telephone number information for the health insurance carrier. In addition, the DoD SIT validation agency assigns the Health Insurance Carrier Id to validated health insurance carriers. If the DoD SIT validation agency determines that the requested update is not correct, it will be rejected. Rejected updates are only returned to the submitting site.

If a health insurance carrier add request is rejected by the DoD SIT validation agency, DEERS will terminate any OHI policy on the DEERS database associated with the

temporary health insurance carrier. All SIT additions and updates that are validated by the DoD SIT validation agency are reported to all systems identified to DEERS as authorized holders of a local copy of the SIT.

5.8.6 Deactivation of a Health Insurance Carrier

The DoD SIT validation agency can also deactivate any health insurance carrier on the SIT. In addition, DEERS will deactivate any OHI policy on the DEERS database associated with the deactivated health insurance carrier. DEERS will report the deactivation of the health insurance carrier to all systems identified to DEERS as authorized holders of a local copy of the SIT.

Deactivation can only be done by the DoD SIT validation agency. All sites with access to the SIT on DEERS will be able to view the deactivated SIT only, as well as the systems identified as authorized holders of a local copy of the SIT.

Until the redesigned DEERS database is available and all the trading partners are able to access the redesigned DEERS database, the DEERS SIT application will be the mechanism for verifying health insurance carriers for OHI. The application will provide adds and updates to the SIT and report rejections or validations of submitted updates.

5.9 Immunization Data

DEERS will maintain immunization data from the services. To meet this requirement, DEERS has developed and implemented an application to store immunization data centrally. A Web application provides statistical reporting and roster functionality.

5.10 Additional Functionality

DEERS will provide additional functionality to the MHS community. This additional functionality is under analysis and includes the following:

- Master Patient Index
- Deoxyribonucleic Acid (DNA) Inquiry event
- The ability for the Armed Forces Institute of Pathology (AFIP) to update DEERS with the existence or non-existence of DNA samples
- Inquiry event detailing the date a sponsor had a human immunodeficiency virus (HIV) test in the Reportable Disease Database (RDDB)
- Patient Name Identification and EBC information in the Corporate Executive Information System (CEIS) data extract
- An interface with the Defense Dental Standard System (DDSS)
- Storage for the dental readiness classification and the last dental examination date transmitted from the DDSS

5.11 Resource Utilization

5.11.1 Performance Characteristics

5.11.1.1 Speed

DEERS is required to respond to on-line data updates (data push) from socket to socket within seven (7) seconds, and respond to on-line data queries (data pull) from socket to socket within four (4) seconds. Internal system response time is defined as the interval of time from the receipt of the last bit of the incoming transaction to DEERS' communications system until the first bit of the response leaves DEERS' communications system.

5.11.1.2 Estimated Monthly Volume

DEERS has requested information from the TRICARE contractors to get more up-to-date information. In addition, DEERS is also looking for updated volume information within its own systems.

Transaction	***Monthly Volume***
Inquiries:	
Eligibility for Enrollment Inquiry	201,876
Enrollment Fee Payment Transaction History Request	N/A
General Health Care Coverage Inquiry	124,502
Health Care Coverage Inquiry for CC&D Activity	N/A – TMA/MCSC
Catastrophic Cap and Deductible Transaction History Request	N/A
Catastrophic Cap and Deductible Totals Inquiry	9,871,917
OHI Policy Inquiry	N/A – OHI/SIT
SIT Inquiry	N/A – OHI/SIT
Nonavailability Statement Inquiry	13,807
Updates:	
Enrollment for Health Benefit Program	201,876
Enrollment Notification from DEERS	N/A
Addition of a Newborn Beneficiary to DEERS	N/A
Re-Enrollment for Health Benefit Program	119,972
Disenrollment (Voluntary, Involuntary, Loss of Eligibility)	175,351
PCM Change	79,981
PCM Cancellation	N/A - MCSC
Transfer of Enrollment	21,756
Enrollment Period Change (Individual and Family)	N/A - MCSC
Enrollment End Reason Code Change	N/A - MCSC
Enrollment/ Disenrollment Cancellation	N/A - MCSC
Enrollment Fee Payment	230,673
Enrollment Fee Waiver Update for an Individual	N/A
Beneficiary Updates	470,587
Catastrophic Cap and Deductible Amounts Update	N/A - MCSC
NAS Issuance	7,801
NAS Cancellation	54
OHI Policy Add	N/A – OHI/SIT
OHI Policy Update	N/A – OHI/SIT
OHI Policy Cancellation	N/A – OHI/SIT
SIT Add	N/A – OHI/SIT

SIT Update	N/A – OHI/SIT
SIT Cancellation	N/A – OHI/SIT

Data calculated from Enrollment Based Capitation (EBC) reports September 1998 – August 1999

N/A: Data not available; transaction does not currently exist

N/A – MCSC: Awaiting data from Managed Care Support Contractors
N/A – OHI/SIT: Awaiting estimates from the OHI/SIT working group
N/A – TMA: Awaiting data from TRICARE Management Activity

5.11.2 Quality Attributes

A System Test Plan will be developed for the overall New Medical Project that describes the approach and process used for qualifying the functional, interface, data, adaptation, and security and privacy requirements. The plan will also describe the test cases and test procedures to be used, entry and exit criteria, and measurements of success. Separate test plans will be developed for the various interfaces and the Interface Engine.

5.11.3 Provisions for Safety, Security, Privacy and Continuity of Operations

The data contained in DEERS falls within the purview of the Privacy Act of 1974, and will be safeguarded in accordance with the applicable system of records notice and DLAR 5400.21. DEERS will also meet the criteria for a class C2 secure system (DoD 5200.28-STD).

Appendix A: Acronyms and Abbreviations

ACTUR	Automated Central Tumor Registry
AD	Active Duty
AIS	Automated information systems
ANSI	American National Standards Institute
ASC	Accredited Standards Committee
ASD (HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MR&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
BRAC	Base Realignment and Closure
C2	A designated level of trust for unclassified automated systems
CDCF	Central Deductible and Catastrophic Cap File
CEIS	Corporate Executive Information System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CHCBP	Continued Health Care Benefit Program
CHCS	Composite Health Care System
COE	Common operating environment
CONUS	Continental United States
COTS	Commercial-off-the-shelf
DC	Direct Care
DD	Department of Defense
DDP	Dependent Dental Plan
DEERS	Defense Enrollment Eligibility Reporting System
DepSecDef	Deputy Secretary of Defense
DII	Defense Information Infrastructure
DISA	Defense Information Systems Agency

DISN	Defense Information Systems Network
DITSCAP	Defense Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DMDC	Defense Manpower Data Center
DMIS	Defense Medical Information System
DMLSS	Defense Medical Logistics Support System
DNA	Deoxyribonucleic acid
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DPO	DEERS Program Office
DRPO	DEERS RAPIDS Program Office
DSO	DMDC Support Office
DTF	Dental Treatment Facility
EBC	Enrollment-Based Capitation
EDI	Electronic Data Interchange
FMDP	Family Member Dental Program
FOC	Full Operational Capability
FY	Fiscal year
GAO	General Accounting Office
GIQD	Government Inquiry of DEERS
HBA	Health Benefits Advisor
HCDP	Health Care Delivery Program
HCFA	Health Care Financing Administration
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIV	Human Immunodeficiency Virus
HL7	Health Level 7. An electronic data interchange (EDI) protocol that standardizes the format for exchanging certain key sets of data among health care computer application systems.
HMO	Health Maintenance Organization

IATO	Interim Approval to Operate
Id	Identifier
ID	Identification
IE	Interface engine
IM	Information Management
IOC	Initial Operational Capability
IPC	Information Processing Center (outdated term—see SMC)
IRTS	Integration and Runtime Specification
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge base
LAN	Local area network
LSN	Location Storage Number
MCSC	Managed Care Support Contractor
MGIB	Montgomery GI Bill
MHS	Military Health System (formerly Military Health Services System)
MPI	Master Patient Index
MSC	Military Sealift Command
MTF	Military Treatment Facility
MVS	Multiple virtual storage

MWR	Morale, Welfare and Recreation
NAS	Nonavailability Statement
NATO	North Atlantic Treaty Organization
NEDB	National Enrollment Database
NMOP	National Mail Order Pharmacy
NOAA	National Oceanic & Atmospheric Administration
NPS	Naval Postgraduate School
OASD (HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OCONUS	Outside the Continental United States
OGP	Other Government Program
OHI	Other Health Insurance
OSD	Office of the Secretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
PC	Personal computer
PCM	Primary Care Manager
PPO	Preferred Provider Organization
RAPIDS	Real-Time Automated Personnel Identification System
RDBMS	Relational database management system
RDDB	Reportable Disease Database
SMC	System Management Center
SSA	Social Security Administration
SSAA	System Security Authorization Agreement
SSN	Social Security Number

TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TCP/IP	Transmission Control Protocol/Internet Protocol
TPC	Third Party Collections
TRDP	TRICARE Retiree Dental Plan
TSRDP	TRICARE Selected Reserve Dental Program
URFS	Unremarried Former Spouse
US.	United States
USC	United States Code
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USCG	United States Coast Guard
USDPP	Uniformed Services Designated Provider Program
USFHP	Uniformed Services Family Health Plan
USPHS	United States Public Health Service
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility (obsolete; see USDPP)
VA	Department of Veterans Affairs
VSAM	Virtual Storage Access Method
X12	An ANSI standard electronic data interchange protocol used within the business community. X12N is the subset of standards for the commercial medical insurance industry, which is of particular interest to MHS and DEERS.

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Appendix B: Glossary of Selected Terms

The following is a list of selected terms and definitions needed to understand this document.

Class	A class is a structure that contains data items and procedures that can be performed on the data items. In AionDS, classes are the major components of a knowledge base.
Multiple Entitlements	An individual may be authorized benefits for more than one reason, such as being the family member of more than one sponsor. One example of a multiple-entitled individual is the child of two active duty service members. In this case, even if the child loses eligibility when one sponsor is no longer on active duty, he or she is still eligible for DoD benefits as the family member of the sponsor who remains on active duty.
Knowledge base (KB)	A program that represents the knowledge that human specialists have in a particular field.
Object	In object-oriented programming, an object is an occurrence of a *class.* (See Class above)
Rule	A statement, of the form "If…Then…," that indicates an action to be taken. For example, the XX rule might indicate that *if* a person's risk level is low, *then* the investment category is XYZ.

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Appendix C: Types of Health Care Delivery Programs (Plan C

People: **Persons on Active Duty**				***Eligibility Requirements:*** **DC**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrollmen**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STANDARD CAT/CAP*	*PRIM CAT/C*
♦ **Direct Care**							
	N/A	N/A	None	None	N/A	N/A	N/A
TRICARE Remote							
	N/A	N/A (enrollment ends upon leaving remote location)	None	None	N/A	N/A	N/A
TRICARE Prime (Note that enrollment is until separation from Active Service.)							
	N/A	Until separation	None	None	N/A	N/A	N/A

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TR enrollees.

People: **Family Members of Active Duty** ***Eligibility Requirements:*** **DC and CHAMI**

Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	**Fiscal Year** *Deductible*	**Enrollment Year*** *Point of Service Deductible*	**Fiscal Year** *STANDARD Catastrophic Cap*	**Enrolln** *PR Catas C*
♦ **TRICARE Standard**							
	E-4 and below	N/A	None	$50/person $100/family	N/A	$1000/family	N/A
	E-5 and above	N/A	None	$150/person $300/family	N/A	$1000/family	N/A
♦ **TRICARE Prime** (Note that rank consideration is at time of enrollment and enrollment period is annual or u eligibility.)							
	E-4 and below	Annual	None	None	$300/person $600/family	$1000/family	N/A
	E-5 and above	Annual	None	None	$300/person $600/family	$1000/family	N/A
♦ **TRICARE Remote**							
	E-4 and below	Annual	None	None	None	$1000/family	N/A

	E-5 and above	Annual	None	None	None	$1000/family	N/A

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap f enrollees.

***People:* Family Members of Active Duty (cont'd)**				***Eligibility Requirements:* DC and CHAMI**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrollmen**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STANDARD Catastrophic Cap**	*PRIM Catastr Cap*
♦ **TRICARE Prime USFHP** (Note that rank consideration is at time of enrollment and enrollment period is an end of eligibility.)							
	E-4 and below	Annual	None	None	$300/person $600/family	$1000/family	N/A
	E-5 and above	Annual	None	None	$300/person $600/family	$1000/family	N/A

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TF enrollees.

People: **Parents and Parents-in-Law of Active Duty**				***Eligibility Requirements:*** **DC**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrollment Y**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STANDARD Catastrophic Cap*	*PRIME Catastrop Cap*
♦ **Direct Care**							
♦ **TRICARE USFHP** (Note that rank consideration is at time of enrollment and enrollment period is annual or eligibility.)							
	E-4 and below	Annual	None	None	$300/person $600/family	$1000/family	N/A
	E-5 and above	Annual	None	None	$300/person $600/family	$1000/family	N/A

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TF enrollees.

People: **Survivors of Active Duty Deceased Sponsors**				***Eligibility Requirements:*** **DC and CH**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**E**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STANDARD Catastrophic Cap*	*C*
♦ **Direct Care**							
	N/A	N/A	None	None	N/A	N/A	N/
♦ **TRICARE Standard**							
	E-4 and below	N/A	None	$50/person $100/family	N/A	$1000/family	N/
	E-5 and above	N/A	None	$150/person $300/family	N/A	$1000/family	N/
♦ **TRICARE Standard for Survivors Of Active Duty Deceased Sponsors** (within one year following sponsc							
	N/A	N/A	None	$150/person $300/family	N/A	$7500/family	N/

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TF enrollees.

People: **Survivors of Active Duty Deceased Sponsors**				***Eligibility Requirements:*** **DC and CHAMI**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrollm**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STANDARD Catastrophic Cap*	*PR Catast C*
♦ **TRICARE Prime**							
	E-4 and below	Annual	None	None	$300/person $600/family	$1000/family	N/A
	E-5 and above	Annual	None	None	$300/person $600/family	$1000/family	N/A
♦ **TRICARE Prime for Survivors of Active Duty Deceased Sponsors** (within one year following sponsor death)							
	N/A	Annual	$230/person $460/family	None	$300/person $600/family	$7500/family	$3000/

- Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for T enrollees.

People: **Transitional Assistance Sponsors**				***Eligibility Requirements:*** **DC and CHA**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrol**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STANDARD Catastrophic Cap*	*P Cata*
♦ **TRICARE Standard**							
	N/A	N/A	None	$150/person	N/A	N/A	N/A
♦ **TRICARE Prime**							
	N/A	Annual	None	None	$300/person $600/family	$7500/family	$300
♦ **TRICARE USFHP** (Note enrollment period is annual or until end of eligibility.)							
	N/A	Annual	None	None	$300/person $600/family	$7500/family	$300

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TF enrollees.

***People*: Family Members of Transitional Assistance Sponsors**				***Eligibility Requirements:* DC and CHAM**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrollme**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STANDARD Catastrophic Cap*	*PRI Catastr Ca*
♦ **TRICARE Standard**							
	N/A	N/A	None	$150/person $300/family	N/A	$7500/family	N/A
♦ **TRICARE Prime**							
	N/A	Annual	None	None	$300/person $600/family	$7500/family	$3000/f
♦ **TRICARE USFHP** (Note that enrollment period is annual or until end of eligibility.)							
	N/A	Annual	None	None	$300/person $600/family	$7500/family	$3000/f

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TR enrollees.

People: **Parents and Parents-in-Law of Transitional Assistance Sponsors** ¦ ***Eligibility Requirements:*** **DC**

Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	**Fiscal Year** *Deductible*	**Enrollment Year*** *Point of Service Deductible*	**Fiscal Year** *STANDARD Catastrophic Cap*	**En** *Ca*
♦ **Direct Care**							
	N/A	N/A	None	None	N/A	N/A	N/A
♦ **TRICARE Prime USFHP**							
	N/A	None	$230/person $460/family	None	$300/person $600/family	$7500/family	$30

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TF enrollees.

People: **Retired Sponsors**				***Eligibility Requirements:*** **DC and CHAM**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrolln**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STD Catastrophic Cap*	*PR Catas C*
♦ **TRICARE Standard**							
	N/A	N/A	None	$150/person	N/A	N/A	N/A
♦ **TRICARE Prime** (Note that enrollment period is annual or until end of eligibility.)							
	N/A	Annual	$230/person $460/family	**None**	$300/person $600/family	$7500/family	$3000
♦ **TRICARE USFHP** (Note that enrollment period is annual or until end of eligibility.)							
	N/A	Annual	$230/person $460/family	**None**	$300/person $600/family	$7500/family	$3000

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TF enrollees.

***People*: Family Members of Retired Sponsors**				***Eligibility Requirements:* DC and CHAM**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrollme**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STD Catastrophic CAP**	*PRI CAT/C*
♦ **TRICARE Standard**							
	N/A	N/A	None	$150/person $300/family	N/A	$7500/family	N/A
♦ **TRICARE Prime** (Note that enrollment period is annual or until end of eligibility.)							
	N/A	Annual	$230/person $460/family	None	$300/person $600/family	$7500/family	$3000/f
♦ **TRICARE USFHP** (Note that enrollment period is annual or until end of eligibility.)							
	N/A	Annual	$230/person $460/family	None	$300/person $600/family	$7500/family	$3000/f

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TF enrollees.

People: **Parents and Parents-in-Law of Retired Sponsors** ¦ ***Eligibility Requirements:*** **DC**

Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	**Fiscal Year** *Deductible*	**Enrollment Year*** *Point of Service Deductible*	**Fiscal Year** *STANDARD Catastrophic Cap**	**Enrolln** *PR Catas C*
♦ **Direct Care**							
	N/A	N/A	None	None	N/A	N/A	N/A
♦ **TRICARE USFHP** (Note that enrollment period is annual or until end of eligibility.)							
	N/A	Annual	$230/person $460/family	None	$300/person $600/family	$7500/family	$3000

* Point of Service deductible and cost-share amounts are cr edited to the fiscal year catastrophic cap for TF enro llees.

People: **Retired Sponsors, Parents and Parents-in-Law**				***Eligibility Requirements:*** **DC and Med**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrollment**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STD Catastrophic Cap**	*PRIM Catastro c Cap*
♦ **Direct Care**							
	N/A	N/A	None	None	N/A	N/A	N/A

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TF enrollees.

People: **Retired Sponsors and Family Members**				***Eligibility Requirements:*** **DC and Medi**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrollmen**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STANDARD Cap*	*PRIM Catastr Cap*
♦ **TRICARE Senior Prime** (Note that enrollment period is annual or until end of eligibility.)							
	N/A	N/A	None	$150/person	N/A	N/A	N/A

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TR enrollees.

People: **Ex-MHS-Eligible**				***Eligibility Requirements:*** **None**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrollmen**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STANDARD Catastrophic Cap*	*PRIM Catastr Cap*
♦ **CHCBP**							
	N/A	60-day period following eligibility	$933 quarter/ individual $1966 quarter/ family	None	N/A	N/A	N/A

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TF enrollees.

***People:* DoD Affiliates**				***Eligibility Requirements:* Reimbursable**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrollmen**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STANDARD Catastrophic Cap*	*PRIM Catastr Cap*
♦ **Direct Care CONUS**							
	N/A	N/A	None	None	N/A	N/A	N/A
♦ **Direct Care OCONUS**							
	N/A	N/A	None	None	N/A	N/A	N/A

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TF enrollees.

People: **DoD Affiliates**				¦ ***Eligibility Requirements:*** **Reimbursable Outpatient CHAMPUS**			
				Fiscal Year	**Enrollment Year***	**Fiscal Year**	**Enrollme**
Plan Options	*Rank Consideration*	*Enrollment Period*	*Enrollment Fee*	*Deductible*	*Point of Service Deductible*	*STANDARD Catastrophic Cap*	*PRIME Catastro Cap*
♦ **Standard CONUS**							
	N/A	N/A	None	None	N/A	N/A	N/A

* Point of Service deductible and cost-share amounts are credited to the fiscal year catastrophic cap for TF enrollees.

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Appendix D: Eligibility for Enrolled Health Care Coverage Plans ba Assigned Health Care Coverage Plans

The term "eligibility" has been used in DEERS to indicate having some mixture of benefits and entitlements following categories:

- Civilian Health Care
- Direct Care
- Morale, Welfare and Recreation (MWR)
- Exchange
- Commissary

Eligibility to these entitlements was governed by Chapter 55, 10 U.S.C; DoD Directive 1330.9, Armed Ser Regulations; DoD 1330.17-R, Armed Services Commissary Regulations (ASCR); DoD Instruction 1015.1 Military Morale, Welfare, and Recreation (MWR); DoD 6010.8-R, "Civilian Health and Medical Program Services (CHAMPUS); and DoD Instruction 1000.13, "Identification (ID) Cards for Members of the Unifo Dependents, and Other Eligible Individuals".

Eligibility takes on a completely new meaning in the future, specifically, the extension of Health Care withi may come to mean, "Do I have a Health Coverage Plan?". Eligibility for DoD benefits and entitlements wi however, eligibility for DoD Health Care indicated by enrollment into a Health Care Delivery Program (HC The HCDP may require some of the qualifications under the previous definition of eligibility for benefits, b eligibility for a specific health care benefit, such as civilian health care, before allowing enrollment into a He Program. The primary example is the TRICARE Senior Prime program.

Certain Health Care Delivery Programs are assigned based on the status of the individual, sponsor or family entitlements as a result of their DoD affiliation and association to a sponsor. One of the factors affecting th enrollment into an Enrolled Health Care Coverage Plan is the person's Assigned Health Care Coverage Plan The following table shows the relationship between Assigned Health Care Coverage Plans and Enrolled He Plans.

ASSIGNED HCDPs THAT FEED ENROLLED HCDPs

Assigned Health Care Coverage Plans	Enrolled Health Care Coverage Plans
Direct Care for Active Duty Sponsors	1. TRICARE Prime Individual Coverage for Active Du

ASSIGNED HCDPs THAT FEED ENROLLED HCDPs

Assigned Health Care Coverage Plans	Enrolled Health Care Coverage Plans
	2. TRICARE Remote Coverage for Active Duty Spons 3. CHCBP Individual Coverage
Direct Care for Active Duty Family Members	1. TRICARE USFHP Individual Coverage for Active 2. TRICARE USFHP Family Coverage for Active Dut 3. TRICARE Remote Individual Coverage for Active 4. TRICARE Remote Family Coverage for Active Dut 5. CHCBP Individual Coverage 6. CHCBP Family Coverage
TRICARE Standard for Active Duty Family Members	1. TRICARE Prime Individual Coverage for Active Du 2. TRICARE Prime Family Coverage for Active Duty 3. TRICARE Remote Individual Coverage for Active 4. TRICARE Remote Family Coverage for Active Dut 5. TRICARE USFHP Individual Coverage for Active 6. TRICARE USFHP Family Coverage for Active Dut 7. CHCBP Individual Coverage 8. CHCBP Family Coverage
Direct Care for Survivors of Active Duty Deceased Sponsors	1. CHCBP Individual Coverage 2. CHCBP Family Coverage
TRICARE Standard for Survivors of Active Duty Deceased Sponsors	1. TRICARE Prime for Survivors of Active Duty Fami
Direct Care for Retired Sponsors and Family Members	1. TRICARE Senior Prime Individual Coverage for Re Members (if previously entitled to Civilian Health Ca
TRICARE Standard for Retired Sponsors and Family Members	1. TRICARE Prime Individual Coverage for Retired Sp Members 2. TRICARE Prime Family Coverage for Retired Spon 3. TRICARE USFHP Individual Coverage for Retired Members 4. TRICARE USFHP Family Coverage for Retired Sp 5. TRICARE Senior Prime Individual Coverage for Re Members
Direct Care for Transitional Assistance Family Members	1. TRICARE USFHP Individual Coverage for Transiti and Family Members 2. TRICARE USFHP Family Coverage for Transitiona Family Members 3. CHCBP Individual Coverage 4. CHCBP Family Coverage
TRICARE Standard for Transitional Assistance Sponsors and Family	1. TRCIARE Prime Individual Coverage for Transition

ASSIGNED HCDPs THAT FEED ENROLLED HCDPs

Assigned Health Care Coverage Plans	Enrolled Health Care Coverage Plans
Members	Family Members 2. TRICARE Prime Family Coverage for Transitional A Family Members 3. TRICARE USFHP Individual Coverage for Transiti and Family Members 4. TRICARE USFHP Family Coverage for Transitiona Family Members 5. CHCBP Individual Coverage 6. CHCBP Family Coverage

Appendix E: Examples

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